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
	AL11969074	A. BUILDING: _____ B. WING _____	05/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING	1061 TOMYN BLVD OCOEE, FL 34761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ841 SS=D	408.823( ) FS In-person Visitation (1) This section applies to , centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the , , licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and	CZ841		

AHCA Form 3020-0001

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

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CZ841	Continued From page 1 providers may not require an essential caregiver to provide such care. (c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects: 1. End-of-life situations. 2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support. 3. The resident, client, or patient is making one or more major medical decisions. 4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently . 5. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver. 6. A resident, client, or patient who used to talk and interact with others is seldom speaking. 7. For hospitals, childbirth, including labor and delivery. 8. . . . . patients. (d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures. (e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section,	CZ841		

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CZ841	Continued From page 2 providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on the facility's in-person visitation policies and procedures and interview, the facility failed to ensure that all the required components to include permissible length of visits and numbers of visitors, essential caregivers, end of life situations, consensual physical contact, and to include that the facility's staff and visitors may not require to submit proof of any or immunization. Findings: On ..... at 3:45 PM, a review of the facility's in-person visitation policies and procedures document dated ....., modified ..... was missing required components from the policy and procedures. Photographic evidence was obtained. On at 4:15 PM, the Administrator stated that the document provided was created by the corporate office. . Class III	CZ841		
A 000	Initial Comments A Relicensure survey and Complaint Investigation #2022005041 were conducted at Inspired Living in Ocoee Assisted Living Facility and Memory Care with Limited Nursing Services (LNS) on . . . . . The facility had deficiencies at the time of the survey visit.	A 000		

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A 025 SS=G	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 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	A 025		

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A 025	Continued From page 4 independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to monitor and supervise 1 of 4 sampled residents to ensure general health, safety, and physical and emotional well-being of the resident (#8). Findings: Review of the Agency for Health Care Administration's (AHCA) internal report revealed on . . . . . at 9 AM, resident #8 was found in bed with diagonal scratches to both sides of her . A steak knife was removed from the resident's possession prior to the start of the morning shift. The physician was contacted, and the resident was transported to the emergency room (ER). A Law Enforcement Officer arrived at facility along with Emergency Medical Services ( ). Investigation revealed the following diagnoses: unspecified with behavioral disturbances, progressive supranuclear	A 025		

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A 025	Continued From page 5 , history of falling, and other impulse . The resident has been at the facility since , of 2021 with no previous indications of behaviors or thoughts. The knife was found in resident's bed. The resident stated her husband brought it in to help cut her food, however the husband denies he brought in the knife. The resident denies making an attempt on her life. Resident #8's spouse stated she attempted a year ago by stepping in a path of a moving bus. The previous attempt was not conveyed to the facility. The resident was transferred for further evaluation. Facility notes dated at 6 AM revealed upon doing care, a caregiver found a knife in resident #8's . The staff did not know where resident #8 got the knife. The resident refused to let go of the knife. Staff were able to take the knife from the resident. The resident did not say where she got the knife. Facility note revealed that on at 6 AM, the nurse entered resident #8's room and found a knife in the resident's . The nurse did not know where the resident got the knife. The resident refused to let go of the knife, but staff was able to take the knife from resident. The resident did not say where she got the knife. Facility note revealed that on at 6:22 PM, the resident denied any related to on . Her skin was intact, and she had . Staff were to monitor the resident. Facility note revealed that on at 8 PM, the Director of Nursing (DON) received a call from a staff member at 7:27 PM that resident #8 had	A 025		

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A 025	Continued From page 6 been found in her apartment in bed holding a knife at 6 AM. Staff said they were able to take the knife from the resident and lock in the cart. The Director of Wellness advised staff to check the room for anything in reach that the resident may use as a weapon or be construed as dangerous. The resident was unable to get out of bed without assistance. Safety checks were to be increased to a minimum every 30 minutes after that incident. Facility note revealed that on at 9 AM, the DON stated the staff relayed that resident #8 was in bed with , closed, , even at 18, and scratch marks seen on both sides of her . The resident did not open her , or talk to staff at this time. The DON said that was baseline behavior for the resident. Facility notes revealed that on at 10 AM, the DON wrote that the physician was informed the resident was being transferred via ambulance to the ER for assessment. The nurse called for assessment and transfer. Facility General Note revealed that on at 10:18 AM, resident #8 stated, "My husband brought me the knife so I can cup up my food." The nurse asked the resident if she tried to harm herself as she had scratches on her . The resident stated I asleep with the knife and probably scratched my with it. Facility note revealed on at 11:46 AM, the hospital nurse called the facility and said resident #8 was being transported to a Hospital that evening. Facility note revealed on at 2:56 AM, resident #8's spouse came to the facility and	A 025		

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A 025	Continued From page 7 stated he did bring in the knife for the resident to use. He further stated he wondered what happened with the silverware. Resident #8's health assessment dated ..... revealed Medical History included ..... 's ..... , ... , ... , hypercapnia, and ..... type II. The resident was wheelchair bound. ..... status was alert, forgetful, ... 's, and ..... . Nursing care included needs assistance with daily living for ..... , bathing, ambulation, self -care, toileting, transferring, and medication administration. The resident was on ..... , and ..... precautions. She was not an elopement risk. The Law Enforcement Report dated ..... at 10:14 AM revealed that the resident had a bloody line across the right side of her ..... . The resident stated her husband brought the knife to cut up her food items. The resident was transported to the hospital for treatment. The resident stated she was not trying to hurt herself. The knife was taken into evidence. On ..... at 2 PM, staff K wrote that during playing a board game with resident #8, the resident asked her whether it was wrong for someone to commit ..... to relieve the burden on someone else. The resident stated she felt like a nuisance to her husband. The resident's hospital record dated ..... revealed the resident was admitted for major ..... , recurrent with ..... features. The record revealed the resident has been at the hospital for 3 weeks, has not gotten	A 025		

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A 025	Continued From page 8 out of bed, and remains at the hospital for further evaluation. On at 10:30 AM, the DON stated on staff went to get resident #8 in her room around 6:30 AM and found the resident with a steak knife in her and when asked to give to staff she would not. She stated it took 2 staff members to take the knife from her, but she did not state she was going to commit . She stated the resident had a 5 centimeter (cm.) and a 2 cm. scratch under her left , and a 2 cm. and a 4 cm. scratch under her right . All scratches were superficial. The resident's husband first denied bringing the knife then later admitted it to law enforcement officers. She stated she called the police and , and the resident was involuntarily held under the Florida Mental Health Act ( ) at the hospital. She stated the resident was then moved to the hospital and has been there ever since. She stated the hospital will not release her because she has . She stated was not called right away because staff never notified her of the incident until the next day. She stated they were supposed to notify her right away, but they did not. She stated the resident stated she wanted to hurt herself when she spoke with her that day, but she did not document it on the resident's medical record. On at 12:55 PM, the spouse of resident #8 stated he believes the facility was aware that his wife had . He stated the facility is wonderful and his wife is taken care of there. He stated he want her to go to the facility. He stated he had brought the knife with him the night before for the dinner he brought her and forgot to take the knife home. He stated he does not think that she tried to commit	A 025		

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A 025	Continued From page 9 . . . . . and really did . . asleep with the knife as she always used to have a pocketknife with her before she went to the facility. On . . . . . at 2:42 PM, staff K stated she was playing board games with resident #8 on . . . . . and the resident told staff K that she was a burden to her husband. The resident then stated she wanted to hurt herself. She stated she never made statements like that before. She stated she reported this to the Memory Care Director that day, which was 3 days before the incident. She stated the resident never displayed any behaviors before.She seemed more despondent. She stated the resident did not mention anything like that after that. She stated she is not aware of any interventions that were put into place after the comment. On at 3:32 PM, the Memory Care Director stated he was told by staff K about resident #8's comment about wanting to hurt herself on . . . . . . He stated he waited for the husband to visit that day and told him about the comment. He stated when the husband came to facility around 4 PM that day, he did not seem concerned about the comment and chuckled about it. The Memory Care Director then stated the resident was only talking about morality not . He stated he did not document the comment in the chart. He stated he checked her room the same day for any sharp objects on . . . . . He stated he did not make the physician aware of the comment. He stated he had no plans in place for when she returned to the facility. On at 9 AM, staff I stated she found resident #8 with the knife and was able to get it away from her. She stated she had scratches on	A 025		

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A 025	Continued From page 10 her . . on both sides below her . . . . She stated she thought she called the DON right away, but she did not until that following evening. She stated the resident got the knife from the husband who brought in dinner the night before the incident, and the resident kept the knife. She stated the resident had never displayed . . . . . or , . . before this incident. She stated the rooms are not checked after a visitation and staff was not aware that the family member brought in a knife with dinner. She stated they were not aware until the next morning when they went to check on her. She stated she was not aware of any that were stated to another staff member. She stated the Memory Care Director never informed any staff or had any meeting regarding resident #8's behaviors or thoughts prior to the incident on . Class II	A 025		
A 034 SS=D	59A-36.007(9) ASSISTIVE DEVICES (9) ASSISTIVE DEVICES. Facilities are responsible for ensuring the safe usage of a resident's assistive devices. (a) The facility must have policies and procedures that include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. (b) Documentation of each assistive device a resident uses must be included in the resident's record. (c) Direct care staff using assistive devices while rendering personal services to residents must know how to operate and utilize the equipment.	A 034		

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A 034	Continued From page 11 (d) All assistive devices must be clean, in good repair, and free of hazards. (e) The facility must encourage and allow the resident to function with independence when using the assistive device. This Statute or Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 5 sampled residents' electric scooter was clean (#10), and failed to ensure its policies and procedures regarding assistive devices included the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. Findings: Review of resident #10's record revealed a facility admission date of . A current 1823, dated , indicated the resident's diagnoses included , , , , , , type 2, and . On at 9:55 a.m., an electric scooter was seen near the bed of resident #10. The scooter was dirty. The resident said she had it for approximately one and a half years and said the facility never cleaned it or discussed with her any options for cleaning it. Review of the facility's motorized wheelchair/scooter policy, dated , revealed it outlined only guidelines for the resident's use of the device within the community, including that the resident was responsible for	A 034		

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A 034	Continued From page 12 cleaning it, and did not include the requirements and methods for assessing the physical condition of assistive devices that may injure the resident and procedures for recommending repair or replacement for the continuing safety of a resident's assistive device. On at 5:30 p.m., the director of nursing confirmed the findings. Class III	A 034		
A 052 SS=D	429.256( ): 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and	A 052		

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A 052	Continued From page 13 helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (h) Using a to perform - level checks. (i) Assisting with putting on and taking off stockings. (j) Assisting with applying and removing an but not with titrating the prescribed settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with bags. (4) Assistance with self-administration does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations.	A 052		

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	AL11969074	A. BUILDING: _____ B. WING _____	05/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRED LIVING	1061 TOMYN BLVD OCOEE, FL 34761

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A 052	Continued From page 14 (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with [illegible], or [illegible] preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with	A 052		

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A 052	Continued From page 15 self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of	A 052		

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A 052	Continued From page 16 medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to ensure the unlicensed staff, who assisted 2 of 2 sampled residents with medications, followed the correct procedures (#14 & #15). Findings: 1. Observations made during a medication pass for resident #14 on ..... at 12:05 p.m. revealed that medication technician (med tech) G sanitized her . then unlocked the medication cart. She removed medication cards from the cart, then compared the prescription labels to the medication observation record (MOR). While standing at the cart, the med tech popped medications from the cards into a cup. She took only the cup to the resident in the dining room. Med tech G handed the cup to the resident, who took the medications without help. 2. Observations made during a medication pass for resident #15 on at 12:19 p.m. revealed that med tech G washed her ., then unlocked the med cart. She removed	A 052		

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A 052	Continued From page 17 medication cards, then compared the prescription label to the MOR. While standing at the cart, she popped medications from the cards into a cup. She took only the cup to the resident in the dining room. The med tech poured the medications into the resident's , then assisted the resident to take a drink of water. Med tech G did not take the medication cards to where the residents were, say the name and dose of each medication aloud, then pour them while in each resident's presence. Following the medication passes, the med tech was asked if she recalled learning that she was required to prepare the medications in the residents' presence. She replied that she did, then said she should have done so for residents #14 and #15. Class III	A 052		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual	A 078		

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A 078	Continued From page 18 basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or	A 078		

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A 078	Continued From page 19 more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience by allowing unlicensed staff to administer medication to 1 of 2 sampled residents (#15). Findings: Observations made during a medication pass for resident #15 on at 12:19 p.m. revealed that medication technician (med tech) G washed her , then unlocked the medication cart. She removed medication cards, then compared the prescription labels to the Medication Observation Record. While standing at the cart, she popped medications from the cards into a cup. She took only the cup to the resident in the dining room. The med tech poured the medications into the resident's , which was a task she was not licensed to do, then she assisted the resident to take a drink of water. Following the medication pass, the med tech confirmed that she poured the medications into the resident's , which was administration of medication. Class III	A 078		

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A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (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. (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. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (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). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation	A 081		

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A 081	Continued From page 21 which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (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 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. (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: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (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:	A 081		

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A 081	Continued From page 22 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (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: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (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. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to have documentation to indicate 1 of 13 sampled staff attended a pre-service orientation that was at least 2 hours in duration and covered the facility's license type	A 081		

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A 081	Continued From page 23 and services offered by the facility (E). Findings: On [redacted] at 9:45 a.m., the facility's administrator identified nurse E as the facility's Limited Nursing Service (LNS) registered nurse (RN), then said the nurse was a corporate nurse. Review of nurse E's personnel record revealed a hire date of [redacted]. The record did not contain documentation to indicate the nurse attended the required 2-hour pre-service orientation, and did not contain documentation to indicate the nurse was core-trained to exempt her from the requirement. On [redacted] at 4:50 p.m., the Human Resource Director confirmed the finding and was unable to provide additional documentation. Class III	A 081		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [redacted] 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	CZ814		

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CZ814	Continued From page 24 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 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: Based on review of the facility's background screening clearinghouse roster and interview, the facility failed to report the initial employment status within 10 business days for 1 of 13 sampled staff (E). Findings: On at 9:45 a.m., the facility's administrator identified nurse E as the facility's Limited Nursing Service (LNS) registered nurse (RN), then said the nurse was a corporate nurse. Review of nurse E's personnel record revealed a hire date of . Review of the facility employee background screening clearinghouse roster on at 3:53 p.m. revealed nurse E had an employment end date of and there was no entry for her re-hire on .	CZ814		

Agency for Health Care Administration

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CZ814	Continued From page 25 On . . . . . at 4:50 p.m., the Human Resource Director confirmed the finding, and said the roster was not updated to reflect nurse E's hire because the nurse was a corporate employee. Unclassified	CZ814		