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
	AL11969415	A. BUILDING: _____ B. WING _____	C 01/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
S & R ASSISTED LIVING FACILITY LLC	907 WOODLAND TERRACE BRANDON, FL 33511

(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
CZ830 SS=D	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

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

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CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient services must utilize an online database	CZ830		

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CZ830	Continued From page 2 approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit a comprehensive emergency management plan (CEMP) annually to the local emergency management office. Findings Included: A review of the facility's CEMP, conducted on [redacted], revealed that the CEMP was approved by the local emergency management office on [redacted]. During an interview with the Administrator, conducted on at 11:15am, the Administrator stated that the facility had not submitted the facility's CEMP to the local emergency management office since the approved CEMP dated /20218. Class III	CZ830		
CZ841 SS=D	408.823( ) FS In-person Visitation (1) This section applies to , [redacted] 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.	CZ841		

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CZ841	Continued From page 3 (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 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	CZ841		

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CZ841	Continued From page 4 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, 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 record review and interview, the facility failed to have a visitation policy and procedures within thirty days of that included control and education policies related to screening, personal protective equipment,	CZ841		

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CZ841	Continued From page 5 permissible length and number of visitors, consensual physical contact between visitors, essential caregiver visits, and a designation of a person responsible for ensuring that staff adhere to the policies and procedures. Furthermore, the facility failed to have a visitation policy and procedures posted on the facility website. Findings Included: A review of the facility ' s website conducted on , revealed that the website did not include a visitation policy and procedures. During an attempt to review the facility visitation policy and procedures, conducted , there was no visitation policy and procedures available for review. During an interview with the Administrator, conducted on at 01:17pm, the Administrator stated that there were no limitations on visitors in the facility and the facility did not have a visitation policy and procedures. Class III	CZ841		
A 000	Initial Comments An abbreviated re-licensure survey and a generator monitoring were conducted at S&R Assisted Living Facility on . Deficiencies were identified at the time of survey.	A 000		
A 007 SS=D	59A-36.006(1) FAC Admissions - Criteria (1) ADMISSION CRITERIA. (a) An individual must meet the following minimum criteria in order to be admitted to a	A 007		

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A 007	Continued From page 6 facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least [illegible] 2. Be free from signs and symptoms of any communicable [illegible] that is likely to be transmitted to other residents or staff. An individual who has [illegible] ( ) may be admitted to a facility, provided that the individual would otherwise be eligible for admission according to this rule. 3. Be able to perform the activities of daily living, with supervision or assistance if necessary. 4. Be able to transfer, with assistance if necessary. The assistance of more than one person is permitted. 5. Be capable of taking medication, by either self-administration, assistance with self-administration, or administration of medication. a. If the resident needs assistance with self-administration of medication, the facility must inform the resident of the professional qualifications of facility staff who will be providing this assistance. If unlicensed staff will be providing assistance with self-administration of medication, the facility must obtain written informed consent from the resident or the resident's surrogate, guardian, or attorney-in-fact. b. The facility may accept a resident who requires the administration of medication if the facility employs a nurse who will provide this service or the resident, or the resident's legal representative, designee, surrogate, guardian, or attorney-in-fact, contracts with a third party licensed to provide this service to the resident. 6. Not have any special dietary needs that cannot be met by the facility. 7. Not be a danger to self or others as determined by a health care practitioner, or a	A 007		

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A 007	Continued From page 7 mental health practitioner licensed under Chapter 490 or 491, F.S. 8. Not require 24-hour licensed professional mental health treatment. 9. Not be bedridden, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 10. Not have any or 4 , . A resident requiring care of a may be admitted provided that: a. The resident either: (I) Resides in a standard or limited nursing services licensed facility and contracts directly with a licensed home health agency or a nurse to provide care; or (II) Resides in a limited nursing services licensed facility and care is provided by the facility pursuant to a plan of care issued by a health care practitioner; b. The condition is documented in the resident's record and admission and discharge logs; and, c. If the resident's condition fails to improve within 30 days as documented by a health care practitioner, the resident must be discharged from the facility. 11. Residents admitted to standard, limited nursing services, or limited mental health licensed facilities may not require any of the following nursing services: a. airway management of any kind, except that of continuous positive airway pressure may be provided through the use of a CPAP or bipap machine; b. Assistance with , c. Monitoring of gases, d. Management of post-surgical drainage tubes and vacuum devices; e. The administration of products in the facility; or	A 007		

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A 007	Continued From page 8 f. Treatment of surgical [illegible] or [illegible], unless the surgical [illegible] or [illegible] and the underlying condition have been stabilized and a plan of care has been developed. The plan of care must be maintained in the resident's record. 12. In addition to the nursing services listed above, residents admitted to facilities holding only standard and/or limited mental health licenses may not require any of the following nursing services: a. [illegible] and [illegible] performed in the facility; b. [illegible] performed in the facility. 13. Not require 24-hour nursing supervision, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.; 14. Not require skilled rehabilitative services as described in Rule 59G-4.290, F.A.C. 15. Be appropriate for admission to the facility as determined by the facility administrator. The administrator must base the determination on: a. An assessment of the strengths, needs, and preferences of the individual; b. The medical examination report required by Section 429.26, F.S.; c. The facility's admission policy and the services the facility is prepared to provide or arrange in order to meet resident needs. Such services may not exceed the scope of the facility's license unless specified elsewhere in this rule; and, d. The ability of the facility to meet the uniform fire safety standards for assisted living facilities established in rule Chapter 69A-40, F.A.C. (b) A resident who otherwise meets the admission criteria for residency in a standard licensed facility, but who requires assistance with the administration and regulation of portable [illegible] or assistance with routine [illegible] care of [illegible] site [illegible] placement, may be admitted	A 007		

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A 007	Continued From page 9 to a facility with a standard license as long as the facility has a nurse on staff or under contract to provide the assistance or to provide training to the resident on how to perform these functions themselves. (c) Nursing staff may not provide training to unlicensed persons, as defined in Section 429.256(1)(b), F.S., to perform skilled nursing services, and may not delegate the nursing services described in this section to certified nursing assistants or unlicensed persons. This provision does not restrict a resident or a resident's representative from [redacted] with a licensed third party to provide the assistance if the facility is agreeable to such an arrangement and the resident otherwise meets the criteria for admission and continued residency in a facility with a standard license. (d) Not withstanding any other provisions of this rule, an individual enrolled in and receiving licensed hospice services may be admitted to an assisted living facility pursuant to Section 429.26(1)(d), F.S. (e) Resident admission criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to meet assisted living facility admissions criteria for one Resident (#5) of one sampled resident that was bedridden at the time of admission, required continuous [redacted] care, and was not admitted to hospice at the time of admission to the facility. Findings Included: During an observation, conducted on	A 007		

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A 007	Continued From page 10 at 10:20am, Resident #5 was in bed. At 10:25am, a hospice Registered Nurse arrived to assess Resident #5. The hospice Registered Nurse stated that Resident #5's [redacted] had to be set at three liters. At 01:20pm, Resident #5 continued in bed with a food tray on a bedside table in front of resident. Resident #5 was not toward the top of the bed and had slid downward. Resident #5's upper body was bent toward the tray table of food. Resident #5 was wearing an [redacted] and was dropping food on herself as she took bites of food. At 03:00pm, Resident #5 continued in bed in the same position as at 01:20pm and none of the facility staff had attempted to move the resident to the [redacted] of the bed. During an interview with Resident #5, conducted on [redacted] at 01:20pm, Resident #5 stated that she had just moved in the facility yesterday (referring to [redacted]). Resident #5 stated that the facility had to perform all activities of daily living for the resident. A record review for Resident #5, conducted on [redacted], revealed that Resident #5 was admitted on an unknown dated as it was not noted in the resident's record. According to Resident #5's health assessment form dated [redacted], Resident #5 had diagnosis which included [redacted] and [redacted] and required [redacted] at three liters via [redacted]. Resident #5's bedridden status was not noted on the health assessment form. There was no documentation that Resident #5 was admitted to hospice services prior to the resident's admission to the facility. There was no consent form agreeing to hospice services. There was no authorization from Resident #5's health provider that the resident may be admitted to	A 007		

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A 007	Continued From page 11 hospice services. There was no interdisciplinary care plan that described the care and services that hospice provided and those that the facility provided. There was no care plan that described how the facility and hospice were going to meet Resident #5's scheduled and unscheduled needs for [redacted] administration, feeding, and positioning as well as other needs (photographic evidence obtained). A review of the facility's admission and discharge log, conducted on [redacted], revealed that Resident #5 was admitted to the facility on [redacted]. A review of the staffing schedule, conducted on [redacted], revealed that the facility had three employees that worked alone in the facility on rotating 24/7 cycles. An employee record review of the facility's three employees, conducted on [redacted], revealed that the facility employees were the Administrator, Staff A, and Staff B. During an interview with the Administrator, conducted on [redacted] at 02:30pm, the Administrator stated that Resident #5 was bedridden and under hospice services. The Administrator stated that Resident #5 had minimal paperwork when the resident was admitted yesterday (referring to [redacted]). Class III	A 007		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements;	A 010		

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A 010	Continued From page 12 examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a	A 010		

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A 010	Continued From page 13 facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection,	A 010		

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A 010	Continued From page 14	A 010		

criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:

(a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S.

(b) A resident requiring care of a may be retained provided that:

1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner,

2. The condition is documented in the resident's record; and,

3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility.

(c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:

1. The resident qualifies for, is admitted to, and consents to receive services from a licensed

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A 010	Continued From page 15 hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assess and determine residents that were no longer appropriate to reside in an assisted living facility who required the use of a [redacted] devise for transfers. Findings Included:	A 010		

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A 010	Continued From page 16 During an observation of Resident #1's room, conducted on [redacted] at 10:20am, there was a sit to stand [redacted] device in Resident #1's room. A record review for Resident #1, conducted on [redacted], revealed that Resident #1 was admitted on an unknown dated as it was not noted in the resident's record. According to Resident #1's health assessment form dated [redacted], Resident #1 required assistance with transfers and needed [redacted] precautions. There was no documentation regarding Resident #1's need for a sit to stand [redacted] device for transfers. A review of the facility's admission and discharge log, conducted on [redacted], revealed that Resident #1 was admitted to the facility on [redacted]. A review of the staffing schedule, conducted on [redacted], revealed that the facility had three employees that worked alone in the facility on rotating 24/7 cycles. An attempt to review the facility's assistive devices policy and procedures, conducted on [redacted], there was no assistive devices policy and procedures to review. During an interview with the Administrator, conducted on [redacted] at 02:30pm, the Administrator stated that staff used a sit to stand mechanical device to transfer Resident #1 and was unaware that a sit to stand [redacted] was prohibited from use in assisted living facilities. At 03:00pm, the Administrator stated that the facility did not have an assistive devices	A 010		

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A 010	Continued From page 17 policy and procedures. The Administrator agreed that there was no documentation related to the use of a sit to stand [illegible] device to transfer Resident #1. Class III	A 010		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of	A 032		

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A 032	Continued From page 18 at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an elopement response policy and procedures in place. Furthermore, the facility failed to conduct two resident elopement drills per year. Findings Included:	A 032		

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A 032	Continued From page 19 An attempt to review the facility's elopement drills, conducted on . . . . . , revealed that there were none available to review. An attempt to review the facility's elopement response policy and procedures, conducted on , revealed that there were none available to review. An employee record review for the Administrator, Staff A, and Staff B, conducted on , revealed that the Administrator, Staff A, and Staff B did not have evidence that the employees completed training regarding elopement response in their employee records. During an interview with the Administrator, conducted on . . . . . at 01:21pm, the Administrator stated that she had not conducted any drills for elopement response. The Administrator stated that the facility did not have an elopement policy and procedures. Class III	A 032		
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	A 034		

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A 034	Continued From page 20 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. (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 observation, record review, and interview, the facility failed to have a policy and procedures for assistive devices. Furthermore, the facility failed to have each assistive device documented in resident records for two Residents (#1 and #3) of two sampled residents that used wheelchairs for ambulation. Findings Included: During observations, conducted on . . . . . from 10:20am through 03:30pm, Resident #1 and #3 used wheelchairs for ambulation. There was a sit to stand in Resident #1's room. A record review for Resident #1, conducted on . . . . . , revealed that Resident #1's health assessment form dated noted that the resident required assistance with ambulation and transfers but did not note that the resident required the use of a wheelchair and sit to stand . There was no documentation in Resident #1's record that the resident used a wheelchair and the sit to stand . A record review for Resident #3, conducted on . . . . . , revealed that Resident #3's health assessment form dated . noted that	A 034		

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A 034	Continued From page 21 the resident had an unsteady gait and required assistance with ambulation and transfers but did not note that the resident required the use of a wheelchair. There was no documentation in Resident #3's record that the resident used a wheelchair. During an attempt to review the facility's assistive devices policy and procedures, conducted on , there was none to review. During an interview with the Administrator, conducted on at 3:00pm, the Administrator stated that the facility did not have a policy and procedures for assistive devices. The Administrator agreed that there was no documentation regarding Resident #1's assistive devices (wheelchair and sit to stand) documented anywhere in Resident #1's record. The Administrator agreed that there was no documentation regarding Resident #3's assistive device (wheelchair) documented anywhere in Resident #3's record. 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, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly	A 052		

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A 052	Continued From page 22 labeled containers. (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 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 . (4) Assistance with self-administration of medication 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.	A 052		

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A 052	Continued From page 23 (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or 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 , 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	A 052		

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A 052	Continued From page 24 429.256(3), F.S., assistance with 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.	A 052		

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A 052	Continued From page 25 (f) Assistance with self-administration of 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 observation, record review, and interview, the facility failed to ensure proper assistance with self-administration of medications by not comparing medication labels with medication observation records, not giving medications within an hour before and an hour after the medication was due, and not verbally informing the name and dose of the medication to one Resident (#4) of one sampled resident that required assistance with self-administration of medication. Findings Included: During a medication pass observation with Staff A for Resident #4, conducted on at 01:03pm, Staff A brought a medication box for Resident #4 to the kitchen counter. Staff A took a pill pack from the box and walked over to Resident #4 at the dining room table. Staff A did not have Resident #4's medication observation record and did not compare the medication label to the medication observation record. Staff A popped a pill from the pill pack into Resident #4's and did not inform the resident the name and dose of the medication.	A 052		

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A 052	Continued From page 26 A review of Resident #4's medication observation record, conducted on . . . . . , revealed that Resident #4 had a prescribed medication . . , . . . 0.5mg due at 12:00pm. During an attempt to review the facility's medication pass policy and procedures, conducted on . . . . . at 03:00pm, there was none provided to review. A review of Staff A's employee record, conducted on . . . . . , revealed that Staff A's employee record did not have evidence that the employee had obtained 6-hours training regarding assistance with self-administration of medications. During an interview with the Administrator, conducted on at 02:10pm, the Administrator agreed that Staff A's employee record did not include evidence that the employee obtained 6-hours training regarding assistance with self-administration of medications. At 03:00pm, the Administrator agreed that Resident #4 received the prescribed 12:00pm medication outside of the hour after timeframe. The Administrator stated that the facility did not have a policy and procedures for the proper assistance with self-administration of medications and that Staff A did not properly assist Resident #4 with medications. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer	A 054		

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S & R ASSISTED LIVING FACILITY LLC	907 WOODLAND TERRACE BRANDON, FL 33511

(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 054	Continued From page 27	A 054		

managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use.
(b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include:
1. The name of the resident and any known [illegible] the resident may have;
2. The name of the resident's health care provider and the health care provider's telephone number;
3. The name, strength, and directions for use of each medication; and,
4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors.
(c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to update Medication Observation Records (MORs) immediately each time medications were offered or given to residents for Residents (#1, #2, #3, #4, and #5). Additionally, the facility failed to maintain MORs free from errors for one Resident (#2). Furthermore, the facility failed to maintain MORs with residents' health provider's

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A 054	Continued From page 28 names and telephone numbers, resident [redacted], and medication names, strength/doses, times, and directions for use of each medication for Residents (#1, #3, #4, and #5) of five sampled residents that required assistance with self-administration of medications. Findings Included: A MORs review for Resident #1, conducted on [redacted], revealed that Resident #1 had two MORs with no month or year noted on either MORs page. One MORs was for morning medications with fourteen medications listed. The other MORs was for evening medications with fourteen medications listed. The morning medications page did not list Resident #1's [redacted]. Most of the medications on both pages had the medication names cut off and did not include the complete names of the medications. None of the medications had the directions of use for the medications. Five of the medications did not include the dose of the medications. Five of the morning medications were not documented as given to the resident on [redacted] at 08:00am. There was no telephone number for Resident #1's health care provider. A MORs review for Resident #2, conducted on [redacted], revealed that Resident #2 had prescribed medications that were not documented as offered or given to the resident which included [redacted] 0.4mg, [redacted] 90mg, [redacted] 20mg, [redacted] Extended Release 20MEQ, [redacted] 1mg, [redacted] 1000mcg, [redacted] 125mcg, and [redacted] 10mg on [redacted] at 08:00am and [redacted] 25mg, [redacted] C 1000mg, and Iron 325mg on [redacted] at 5pm and [redacted] at 8am. Resident #2's had prescribed	A 054		

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A 054	Continued From page 29 medications that were documented as given twice to the resident on each day and the medications were ordered as once per day which included 10mg on , , , , and from through and , 5mg on , , , , , and . Resident #2 had prescribed D2 1.25mg take one capsule by once a week on Saturdays that was documented as given on , , , , and . A review of the , calendar, conducted on , revealed that Saturdays on , , , , and for . A MORs review for Resident #3, conducted on , revealed that Resident #3 had two MORs with no month or year noted on either MORs page. One MORs was for morning medications with eleven medications listed. The other MORs was for evening medications with five medications listed. The morning medications page did not list Resident #3's health care provider's name and telephone number and the evening medications page did not list Resident #3's health care provider's telephone number. All the medications on both pages had the medication names cut off and did not include the complete names of the medications. None of the medications had the directions of use for the medications. All the morning medications were not documented as given to the resident on at 08:00am. A MORs review for Resident #4, conducted on , revealed that Resident #4 had medications that were not documented as offered	A 054		

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A 054	Continued From page 30	A 054		

or given to the resident which included:
, 25mcg on , ,
and at 06:00am; , 20mg,
40mg, and on
, , and at
08:00am; 12.5mg on
, , and at
08:00am and from through
, , and from
through at 05:00pm; ,
500mg on , , and
at 08:00am and from
through at 05:00pm; ,
0.5mg on , , and
at 08:00am and ,
, /023, and at
12:00pm and , , and
at 05:00pm; , 5mg on
and at 08:00pm; and
40mg from
through at 08:00pm. Resident #4's
had prescribed medications that had no times
noted to give the medications which include
Jardiance 10mg, , 81mg, ,
25mg, and 25mg.

A MORs review for Resident #5, conducted on , revealed that Resident #5 had two MORs One MORs was for morning medications with six medications listed. The other MORs was for evening medications with five medications listed. None of the medications had the directions of use for the medications which included , , , , , , , , , , and . There was no name or telephone number for Resident #5's health care provider on either page.

An employee record review for the Administrator

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A 054	Continued From page 31 and Staff A and B, conducted on . . . . . , revealed that the Administrator and Staff A and B's employee records did not contain evidence that they obtained 6-hours training regarding assistance with self-administration of medications. During an interview with the Administrator, conducted on . . . . . at 02:10pm, the Administrator agreed that employee records for herself and Staff A and B did not contain evidence that the employees obtained 6-hours training regarding assistance with self-administration of medications. At 03:00pm, the Administrator agreed that MORs had medications that were not documented as offered or given to Residents #1, #2, #3, #4, and #5. The Administrator agreed that MORs did not include residents' . . . and health care provider's names and telephone numbers. The Administrator agreed that MORs had medications that did not include the complete medications names, strength/doses, times, and directions of use for Residents #1, #3, #4, and #5. The Administrator agreed that MORs were not free from errors for Resident #2. (photographic evidence obtained) Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their	A 055		

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A 055	Continued From page 32 possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is	A 055		

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A 055	Continued From page 33 located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing	A 055		

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A 055	Continued From page 34 pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed keep centrally stored medications locked and secured at all times. Furthermore, the facility failed to dispose of abandoned medications within thirty days of abandonment. Findings Included: During an observation, conducted on from 09:45am through 03:45pm, the medication closet was kept unlocked throughout survey. On top of the desk, were pill bottles and liquid medication bottles that included: , 20mg for Resident #3, 25mg for Resident #4, Milk of Magnesia and for former Resident #7, and 100mg for former Resident #8. There was a box of medications that contained pill packs for former Resident #6 on the floor under the desk in the open room which included 400mg, 1mg, , 5mg, and D2 1.25mg. (see photographic evidence). A review of the facility's admission and discharge log, conducted on , revealed that former Resident #6 was discharged on , Resident #7 was discharged on and Resident #8 was discharged on . During an interview with the Administrator, conducted on at 02:30pm, the Administrator agreed that Residents #6, #7, and #8 no longer resided at the facility. At 03:00pm, the Administrator agreed medications were supposed to be locked and secured at all times.	A 055		

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A 055	Continued From page 35 (photographic evidence obtained) Class III	A 055		
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 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	A 078		

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A 078	Continued From page 36 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 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 record review and interview, the facility failed to obtain a one-time statement from a health care provider that one employee (Staff B) was free from communicable . Furthermore, the facility failed to obtain evidence that employees were free from ( ) from a health care provider annually for three employees (Administrator, Staff A, and Staff B) of	A 078		

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A 078	Continued From page 37 three sampled employees. Findings Included: An employee record review for the Administrator, conducted on , revealed that there was no evidence from a health care provider annually that the employee was free from . The Administrator was hired on 11/16/2018. An employee record review for Staff A, conducted on , revealed that there was no evidence from a health care provider annually that the employee was free from . Staff A was hired on . An employee record review for Staff B, conducted on , revealed that Staff B's employee record did not have a one-time statement from a healthcare provider that the employee was free from communicable . There was no evidence from a health care provider that the employee was free from . Staff B was hired on . During an interview with the Administrator, conducted on at 02:10pm, the Administrator agreed that herself and Staff A's employee records did not have evidence from a healthcare provider annually that the employees were free from . The Administrator agreed that Staff B's employee record did not contain a one-time statement from a health care provider that the employee was free from communicable or . Class III	A 078		

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A 081	Continued From page 38	A 081		
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	A 081		

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A 081	Continued From page 39	A 081		

employee completed the preservice orientation 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

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A 081	Continued From page 40 following subjects: 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 record review and interview, the facility failed to provide direct care staff with the required in-service trainings, which included trainings regarding activities of daily living and behavioral	A 081		

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A 081	Continued From page 41 needs, elopement response, emergency procedures and adverse incident reporting, incident reporting, and resident rights and recognizing and reporting , neglect, and , within thirty-days of hire for three employee (Administrator, Staff A, and Staff B) of three sampled employees. Findings Included: An employee record review for the Administrator, conducted on , revealed that the Administrator's employee record did not contain evidence that the employee obtained training regarding elopement response within thirty days of employment. The Administrator was hired on . An employee record review for Staff A, conducted on , revealed that Staff A's employee record did not contain evidence that the employee obtained trainings regarding activities of daily living and behavioral needs, elopement response, emergency procedures and adverse incident reporting, incident reporting, and resident rights and recognizing and reporting , neglect, and , within thirty-days of hire. Staff A was hired on . An employee record review for Staff B, conducted on , revealed that Staff B's employee record did not contain evidence that the employee obtained trainings regarding elopement response, emergency procedures and adverse incident reporting, incident reporting, and resident rights and recognizing and reporting , neglect, and , within thirty-days of hire. On , Staff B obtained one-hour of the three required hours for training regarding activities of daily living and behavioral needs.	A 081		

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A 081	Continued From page 42 Staff B was hired on . . . . . . During an interview with the Administrator, conducted on at 02:10pm, the Administrator agreed that her employee record did not contain evidence that the employee obtained training regarding elopement response within thirty days of hire. The Administrator agreed that Staff A and B's employee records did not contain evidence that the employees completed trainings regarding activities of daily living and behavioral needs, elopement response, emergency procedures and adverse incident reporting, incident reporting, and resident rights and recognizing and reporting . . . . . , neglect, and . . , . . within thirty-days of hire. Class III	A 081		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication	A 084		

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A 084	Continued From page 43 including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for [illegible] control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, [illegible] dosage forms, and [illegible] dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse	A 084		

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A 084	Continued From page 44 reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training	A 084		

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A 084	Continued From page 45 that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed ensure that employees had six-hours training regarding assistance with self-administration of medications prior to assisting residents with medications for three employees (Administrator and Staff A and B) of three sampled employees that assisted residents with self-administration of medications. Findings Included: An employee record review for the Administrator, conducted on . . . . . , revealed that the Administrator had 4-hours training regarding assistance with self-administration of medications dated . There was no evidence that the Administrator obtained two-hour update on new duties allowed after . There was no evidence that the Administrator obtained two-hours continuing education regarding assistance with self-administration of medications for the years 2018 and 2019 in the Administrator's	A 084		

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A 084	Continued From page 46 employee record. The Administrator was hired on [redacted]. An employee record review for Staff A, conducted on [redacted], revealed that Staff A did not have evidence of obtaining six-hours training regarding assistance with self-administration of medications in Staff A's employee record. Staff A was hired as an unlicensed Medication Technician on [redacted]. An employee record review for Staff B, conducted on [redacted], revealed that Staff B did not have evidence of obtaining six-hours training regarding assistance with self-administration of medications in Staff B's employee record. Staff B was hired as an unlicensed Medication Technician on [redacted]. During an interview with the Administrator, conducted on [redacted] at 02:10pm, the Administrator agreed that herself and Staff A and B assisted residents with self-administration of medications. The Administrator agreed that herself and Staff A and B's employee records did not contain evidence of obtaining six-hours training regarding assistance with self-administration of medications. Class III	A 084		
A 085 SS=D	59A-36.011(7) FAC Training - Nutrition & Food Service (7) NUTRITION AND FOOD SERVICE. The administrator or person designated by the administrator as responsible for the facility's food service and the day-to-day supervision of food service staff must obtain, annually, a minimum of	A 085		

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A 085	Continued From page 47 2 hours continuing education in topics pertinent to nutrition and food service in an assisted living facility. This requirement does not apply to administrators and designees who are exempt from training requirements under paragraph 59A-36.012(1)(b). A certified food manager, licensed dietician, registered dietary technician or health department sanitarian is qualified to train assisted living facility staff in nutrition and food service. This Statute or Rule is not met as evidenced by: Based on interview and record review, facility failed to have staff responsible for the facility's food service and the day-to-day supervision of food service obtain a minimum of two-hours continued education annually in topics pertinent to nutrition and food service in an assisted living facility for three employees (Administrator, Staff A, and Staff B) of three sampled employees that worked alone in the facility during mealtimes. Finding Included: An employee record review for the Administrator, conducted on , revealed that the Administrator obtained one-hour of training regarding nutrition and safe food handling on and . An employee record review for Staff A, conducted on , revealed that Staff A obtained one-hour of training regarding nutrition and safe food handling on . An employee record review for Staff B, conducted on , revealed that Staff B obtained one-hour of training regarding nutrition and safe food handling on .	A 085		

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A 085	Continued From page 48 A review of the employee work schedule, conducted on , revealed that each employee worked alone in the facility on 24-hour shifts during meal times. During an interview with the Administrator, conducted on at 12:41pm, the Administrator stated that none of the employees had two-hours of training regarding nutrition and food service and that the employees had one hour of the training. Class III	A 085		
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	A 091		

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A 091	Continued From page 49 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: Based on record review and interview, the facility failed to have training certificates documented in the facility's personnel files for two employees (Administrator and Staff B) of three sampled employee. Findings Included: An employee record review for the Administrator and Staff B, conducted on , revealed that there were training certificates that were not present in the Administrator's and Staff B's personnel files. During the review the Administrator obtained the documents from her personal cellular telephone. The document presented for the Administrator was evidence of high school education dated . The documents presented for Staff B included trainings regarding control (dated), activities of daily living and behavioral needs (dated), nutrition and safe food handling (dated), and (dated). During an interview with the Administrator, conducted on at 02:10pm, the Administrator stated that she had not printed the evidence for her high school education or Staff B's training certificates yet.	A 091		

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A 091	Continued From page 50 Class III	A 091		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule.	A 093		

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A 093	Continued From page 51 The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between	A 093		

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A 093	Continued From page 52 the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to have a menu that was signed and dated for approval with the Registered Dietitian's original signature. Furthermore, the facility failed to have portion sizes noted on the menu or on a separate sheet. Findings Included: A review of the weekly planned and posted menu,	A 093		

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A 093	Continued From page 53 conducted on . . . . . , revealed that there was no original signature of the Registered Dietitian. The menu was not dated by the Registered Dietician unable to determine whether the menu had been approved within one year. There were no portion sizes noted on the menu. During an interview with the Administrator, conducted on . . . . . at 12:41pm, the Administrator agreed that the was not date and original signature of the Registered Dietitian noted on the weekly menu. Class III	A 093		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable:	A 161		

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A 161	Continued From page 54 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ⌄ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain personnel records for each employee that contained an employment application with references for two employees (Staff A and B) of two sampled employees. Findings Included:	A 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969415	A. BUILDING: _____ B. WING _____	C 01/18/2023

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A 161	Continued From page 55 An employee record review for Staff A and B, conducted on . . . . . , revealed that Staff A and B's employee records did not contain an employment application and a list of references. Staff A was hired on . Staff B was hired on . . . . . . During an interview with the Administrator, conducted on at 02:10pm, the Administrator agreed that Staff A and B's employee records did not contain their employment applications and a list of references. The Administrator was unable to provide Staff A and B's employment application. Class III	A 161		
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	CZ814		

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CZ814	Continued From page 56 criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [redacted] 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; [redacted]; 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 record review and interview, the facility failed to maintain the employment status of staff members on the facility's background screening clearinghouse employee roster within ten-business days of employment and termination of two current and former employees (Staff B and C) of four sampled current and former employees (photographic evidence obtained). Findings Included: A review of the facility's background screening clearinghouse employee roster, conducted on [redacted], revealed that Staff B and Staff C were listed as current employees with no dates of termination. Staff B was not listed as a current employee. A review of B's employee record, conducted on [redacted], revealed that Staff B was hired on [redacted]. During an interview with the Administrator, conducted on [redacted] at 11:58am, the Administrator stated that Staff C had not worked at the facility since [redacted]. The Administrator stated that Staff B had not been added to the	CZ814		

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CZ814	Continued From page 57 facility's background screening clearinghouse employee roster and agreed that it was not up to date. Unclassified	CZ814		
CZ815	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. (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	CZ815		

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CZ815	Continued From page 58 employer or the licensee. (3) All [illegible] 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 [illegible] 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: (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	CZ815		

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CZ815	Continued From page 59 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. (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	CZ815		

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CZ815	Continued From page 60	CZ815		

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 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

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CZ815	Continued From page 61 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 [illegible] 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 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	CZ815		

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CZ815	Continued From page 62	CZ815		

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 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,

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CZ815	Continued From page 63 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 employees had an eligible level 2 background screening every five years for one employee (Administrator) of three sampled employees. Findings Included: A review of the Administrator's employee record, conducted on , revealed that the Administrator's eligible level 2 background screening was dated . During an interview with the Administrator, conducted on at 02:10pm, the Administrator agreed that her eligible level 2 background screening was greater than five years ago.	CZ815		

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CZ815	Continued From page 64 Unclassified	CZ815		
CZ816	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 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	CZ816		

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CZ816	Continued From page 65 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; (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	CZ816		

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CZ816	Continued From page 66 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. (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	CZ816		

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CZ816	Continued From page 67 failed to obtain a signed affidavit or attestation of compliance for two employees (Administrator and Staff B) of three sampled employees. Findings Included: A record review for the Administrator, conducted on , revealed that the Administrator's employee record did not contain a signed affidavit or attestation of compliance. The Administrator was hired on . A record review for Staff B, conducted on , revealed that Staff B's employee record did not contain a signed affidavit or attestation of compliance. Staff B was hired on . During an interview with the Administrator, conducted on at 02:10pm, the Administrator agreed that employee records for herself and Staff B did not contain a signed affidavit or attestation of compliance. Unclassified	CZ816		