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
	AL11969133	A. BUILDING: _____ B. WING _____	C 04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASHORE SENIOR LIVING	699 N DIXIE FREEWAY NEW SMYRNA BEACH, FL 32168

(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	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		

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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 facility document review and staff interview, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) to the County Emergency Management Department timely. This has potential to affect all residents in the event of an emergency. The findings include: Record review of the facility's CEMP found no evidence of a letter of approval for the plan in the last year. Review of the Certificate of Approval by Volusia County revealed the certificate was valid through . . It was issued , . . . , to the previous owner of the facility. The letter of approval from the Volusia County Emergency Management department was dated . Photographic evidence obtained. During an interview with the Administrator on at 11:10 AM, she stated that the last submission of the CEMP that she was aware of and could confirm was from . . . . . . During a second interview with the Administrator on at 12:21 PM, she stated that she got information from the facility's corporate office regarding the last submission. She had the dates written on piece of notebook paper. She was asked to produce documentation of the submission from the Volusia County Emergency Management System. She stated she had had a	CZ830		

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CZ830	Continued From page 3 conversation with the Administrative Coordinator II from the Volusia County Emergency Management System and no submission was on file since . The Administrator confirmed the date of the change of ownership was . Class III	CZ830		
A 000	Initial Comments A change of ownership licensure survey and complaint survey 2023001821, 2022010101, 2022001520, 2022002227, 2023003431, 2022005018, was conducted at Seashore Senior Living on , , 2023. The facility had deficiencies at the time of the investigation.	A 000		
A 007	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 facility holding a standard, limited nursing services, or limited mental health license: 1. Be at least . 2. Be free from signs and symptoms of any communicable that is likely to be transmitted to other residents or staff. An individual who has ( ) 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	A 007		

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A 007	Continued From page 4 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 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 [illegible] or 4, [illegible]. A resident requiring care of a [illegible], 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	A 007		

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A 007	Continued From page 5 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 f. Treatment of surgical or , unless the surgical or 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. , and , performed in the facility; b. , , performed in the facility. 13. Not require 24-hour nursing supervision,	A 007		

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A 007	Continued From page 6 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 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 [illegible] with a licensed third party to provide the assistance if	A 007		

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A 007	Continued From page 7 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 observation, staff interview, resident interview and clinical record review, the facility failed to ensure one of fourteen sampled residents met the residency criteria for admission (Resident #11). The findings include: During a tour of the third floor of the facility on . . . . . at 10:30 AM, Resident #11's room was observed with a Personal Protective Equipment (PPE) apron hanging on the door with two boxes of disposable gloves and several masks available for the staff's use. There was a sign on the door that read,"Please no visitors: Check with the wellness department. Thank you." Photographic evidence obtained. Review of the Order Summary Report for Resident #11 from his prior residence dated included the diagnosis of due to . . . . . (.). Photographic evidence obtained. At 10:40 AM on , the Administrator	A 007		

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A 007	Continued From page 8 and the Health and Wellness Coordinator were interviewed. They explained Resident #11's sister made decisions for him. They were unable to provide documentation that Resident #11 was deemed incapable of making his own decisions. During an interview with Resident #11 on at 11:43 AM, he explained he did not want to be at the facility and said he felt like he was in "prison." During a second interview with the Administrator and the Health and Wellness Coordinator on at 12:42 PM, they both confirmed knowledge that Resident #11 was in isolation for . Resident #11 explained in an interview on at 9:30 AM that he had for 8 months and it had not gotten any better. Review of the Health Assessment form (1823) dated in the clinical record for Resident #11 revealed special precautions listed were positive . The 1823 confirmed Resident #11 had, "A communicable , which could be transmitted to other residents or staff." The form also indicated Resident #11 was totally dependant on staff assistance for toileting. Photographic evidence obtained. Class III	A 007		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS.	A 032		

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A 032	Continued From page 9 (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 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	A 032		

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A 032	Continued From page 10 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 staff interview, the facility failed to conduct elopement drills that included participation of all employees for two of two years sampled. The findings include: Record review of the elopement drills provided by the facility revealed a drill was conducted on ..... with four staff in attendance, another drill was conducted on ... with five staff members in attendance and a third drill was conducted 7 staff members in attendance. During an interview with the Administrator on at 10:40 AM, she was asked if she has all staff participate in the elopement drills. She stated that employees not working at the time of	A 032		

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A 032	Continued From page 11 the drill did not participate. She stated there were no drills when she started at the end of and that drills did not include all employees. She provided documentation with the names of the staff that participated in the drills. When the drills were conducted on there were 7 employees that did not participate. Photographic evidence obtained. Class III	A 032		
A 036	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use	A 036		

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A 036	Continued From page 12 according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation, staff interview, resident record review and facility policy and procedure review, the facility failed to provide services in a manner that reduced the risk of transmission of . . . . . Direct care staff failed to use universal precautions after providing care to a resident on transmission based precautions (isolation) for ( ) and one staff failed to change her disposable gloves after they became contaminated during the lunch meal service. Failure of direct care staff who worked throughout the building to follow standard precautions placed all residents at risk for exposure to . The findings include: 1. During a tour of the third floor of the facility on . . . . . at 10:30 AM, Resident #11's was observed with a Personal Protective Equipment (PPE) apron hanging on the door with two boxes of disposable gloves and several masks available for the staff's use. There was a sign on the door that read: Please no visitors: Check with the wellness department. Thank you (Photographic evidence obtained). Employee B, medication technician/caregiver, was observed on . . . . . at 10:36 AM exit Resident #11's room. She was wearing a blue PPE gown, latex gloves and a mask. She was carrying a plastic bag with soiled linen in it. She walked down the hallway to the room marked laundry, approximately 50 from . She went into the laundry room and dropped off the bag and returned to Resident #11's room.	A 036		

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A 036	Continued From page 13 Employee E, medication technician/caregiver, was seen opening Resident #11's door where she stood in the doorway with her PPE on. They both went into the room and shut the door. At 10:42 AM the door to Resident #11's room opened and Employee B walked out carrying a plastic bag of garbage. She still had her PPE gown and gloves on. Employee E walked down the hallway while rolling her PPE gown up into a ball against her personal clothing. When asked if they had received training on control Employee B stated "Yes." Employee E pushed her contaminated gown into the garbage receptacle attached to the medication cart outside the laundry room. When asked if they were supposed to be exiting the isolation room with their PPE on Employee E stated "I didn't have a garbage can to put it in, in the room. She did not proceed to put a garbage can in the resident's room. Employee B stated that they were "just changing his sheets." When asked if the resident was in the bed during the task, they confirmed that he stayed in the bed while they changed his sheets. They both got on the elevator and went downstairs. Neither were observed to wash or their . Review of the Health Assessment form (1823) dated for Resident #11 revealed he was positive for the question that asked about special precautions. When prompted to disclose whether the individual had any communicable , which could be transmitted to other residents or staff, the "Yes" box was checked. Review of the Order Summary Report for Resident #11 from his prior residence dated included the diagnosis of due to Photographic evidence obtained.	A 036		

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A 036	Continued From page 14 During an interview with the Administrator and the Health and Wellness Coordinator (H&WC) on at 12:42 PM, they both confirmed that Resident #11 is in isolation for . During an interview with Employee G, medication technician/caregiver, on at 9:20 AM, she was observed to be in Resident#11's room providing care. She had a PPE gown, gloves and mask on. When she was getting ready to exit the room, she took off her PPE and put it in a plastic garbage bag. She tied the bag up and exited the room. When asked if she had washed her , she stated that she had not. She stated there was no soap in the resident's room. She stated she would wash her in the laundry room down the hall approximately 50 away. She then left the interview carrying the garbage bag and went to the laundry room. She opened the door to the laundry room by touching it with her contaminated . During an interview with Resident #11 on at 9:30 AM, he stated he understood that he was in isolation for . He has had for about eight months now and it has not gotten any better. During an interview with Employee E on at 10:05 AM, she stated that she was trained on transmission based precautions on . The H&WC was in the Resident #11's room with Employee E and Employee B. She confirmed that she should not have been rolling up her PPE gown and gloves as she was walking down the hallway. She should have thrown them away in the isolation room. She stated they need a bigger garbage can in his room to discard their PPE.	A 036		

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A 036	Continued From page 15 During an interview with Employee B on at 10:28 AM, she stated on at 10:36 AM, she had just stepped into the isolation room and then realized she had forgotten something so she stepped out and walked down the hallway to get it. During an interview with the H&WC on at 11:50 AM, she stated when Resident #11 was admitted on she gave a demonstration training for both Employee B and E on when both employees returned to work. She did not look in the room to see if there was soap and paper towel and garbage receptacles for the contaminated PPE. She just assumed that there was. The resident's sister helped move him in and set up his room so he had everything he needed. She knew the garbage cans were very small and she put a bigger one in his room today. She confirmed that the staff were not using universal precautions and should not have been leaving the isolation room with PPE on that was contaminated. They should have washed their in the resident's room prior to exiting. Review of the employee records for Employee B and E revealed Employee B had received Control training on . Her date of hire was . Employee E received Control training on . Her date of hire was . Employee G was hired and had control training on . Review of the facility policy and procedure entitled Universal Precautions H-105 revealed it read: Purpose: To prevent the spread of from one resident to another. To protect staff from	A 036		

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A 036	Continued From page 16 . . . . . To prevent the transfer of communicable . To prevent the spread of . . . . . C. Advanced Procedures: Once the facility has been instructed by physician that Personal Protective Equipment (PPE) is needed to help prevent the spread of the following procedure will be implemented. 2. Do not wear PPE outside of isolation area. 4. After PPE is used it must be placed in the bio hazardous waste basket in Resident room before exiting apartment. Use safe work practices to protect yourself and limit the spread of contamination. Keep . . . away from . . ., limit surfaces touched, change gloves when torn or heavily contaminated, perform . . hygiene. How to safely remove personal protective equipment. Gloves: Outside of gloves are contaminated! Gown: The gown front and sleeves are contaminated! Fold or roll into a . . . . and discard in a waste container. 5. Wash . . or use an . . . . -based . . sanitizer immediately after removing all PPE. Photographic evidence obtained. Class III	A 036		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer 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	A 054		

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A 054	Continued From page 17 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 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 , 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 observation, clinical record review, staff interview and facility policy and procedure review, the facility failed to maintain an accurate electronic medication observation record (e-MOR)for one resident out of 4 residents sampled for medication pass observation (Resident #12). The findings include: Employee E, Medication Technician, was observed assisting with medications on at 10:13 AM. She read the e-MOR and proceeded to prepare the medication for Resident #12. The e-MOR read: , 2mg. Dose: 2 tablet (total of 4mg) tablet. Instructions said to take 2 tablets for a	A 054		

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A 054	Continued From page 18 total of 3mg ... - four times daily, orally. Photographic evidence obtained. The medication label read: ... 3mg. Give one tablet by ... four times a day. Photographic evidence obtained. Review of the clinical record for Resident #12 revealed the physician's orders read: ... 3mg tablet. Take 1 tablet four times daily (Photographic evidence obtained). During an interview with the Health and Wellness Coordinator (H&WC) on ... at 10:00 AM, she reviewed the e-MOR for Resident #12 and confirmed that the order on the e-MOR did not match the current physician's order or the label. She produced the physician's order sheet for ... Review of the physician's order sheet for ... indicated the order matched the label. The H&WC stated she was not working here at the time and the previous H&W Director entered the order into the e-MOR system. She confirmed that the order was entered incorrectly. Review of the facility policy and procedure entitled Medication Technicians Assisting with Self-Administration of Medications, Document 1.2, dated ... revealed staff was to gather all necessary supplies for procedure, and compare the MOR to the label when passing medications. Photographic evidence obtained. Class III	A 054		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1)	A 081		

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A 081	Continued From page 19 (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by	A 081		

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A 081	Continued From page 20 the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its	A 081		

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A 081	Continued From page 21 . . . . . 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 employee record review and staff interview, the facility failed to ensure 1 of 4 employees reviewed, Employee B received training in control prior to interacting with residents. The facility also failed to ensure 1 of 4 employees, Employee C, received at least one hour in training . . . control, safe food handling, reporting . . and neglect, incident	A 081		

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A 081	Continued From page 22 reporting, or 3 hours of training in resident behaviors and providing assistance with activities daily living within 30 days of employment. The findings include: Record review for Employee B, hired , received one hour of training in control. Employee C's file showed a hire date of . There was no evidence Employee C received at least one hour in training in control, safe food handling, reporting and neglect, incident reporting, or 3 hours of training in resident behaviors and providing assistance with activities of daily living. The findings were confirmed during an interview with the Administrator on at 3:00 PM. She was notified of the missing information from the employee files. She stated she was aware the training had not been completed. Class III	A 081		
A 082	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of	A 082		

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A 082	Continued From page 23 this rule. This Statute or Rule is not met as evidenced by: Based on employee record review and staff interview, the facility failed to ensure that 1 of 4 employees reviewed received training in / (/) within 30 days of employment (Employee C). The findings include: Record review for Employee C, hired , found no evidence the employees received training in / . The findings were confirmed during an interview with the Administrator on at 3:00 PM. She was notified of the missing information from the employee files. She stated she was aware the training had not been completed. Class III	A 082		
A 090	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after	A 090		

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A 090	Continued From page 24 employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on employee record review and staff interview, the facility failed to ensure 1 of 4 sampled employees received at least one hour of training in the facility's policies and procedures regarding ( ) within 30 days after employment. (Employee B) The findings include: Record review for Employee C, hired , found no evidence found no evidence the employee received one hour of training in the facility's policies and procedures regarding 's. The findings were confirmed during an interview with the Administrator on at 3:00 PM. She was notified of the missing information from the employee files. She stated she was aware the training had not been completed and had called the employee to come in to the facility to finish her online training. Class III	A 090		