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
	AL11968966	A. BUILDING: _____ B. WING _____	09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTRY PARK ORLANDO	3201 CENTER POINT DR ORLANDO, FL 32825

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CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] 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 5 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] 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; [illegible]; 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 the Background Screening (BGS) website, personnel record review and interview, the facility failed to update 1 of 4 sampled staff (B) on the BGS Employee Roster within 10 business days as required.	CZ814		

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CZ814	Continued From page 1 Findings: Med Tech B's personnel record review revealed a hire date of [redacted]. She has an eligible Level 2 BGS eligibility dated [redacted]. On [redacted] at 3:30 PM, reviewed the BGS Employee Roster and Med Tech B was not listed or updated 10 business days after employment. On [redacted] at 4:20 PM, an interview with the Business Office Manager confirmed the findings. Unclassified	CZ814		
A 000	Initial Comments A re-licensure survey and generator monitoring was conducted on [redacted] at Gentry Park Orlando. The facility had deficiencies at the time of the survey.	A 000		
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	A 032		

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A 032	Continued From page 2 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 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	A 032		

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A 032	Continued From page 3 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 reviews and interview, the facility failed to have documentation to indicate 2 of 4 staff participated in a minimum of two resident elopement drills each year (A and administrator). Findings: A review of caregiver A's personnel record revealed a hire date of . A review of the facility's 2022 resident elopement drills revealed they were conducted on . . . . . , and . Neither caregiver A nor the administrator were listed as participants on any of them. The Administrator's personnel record review revealed a hire date of . There was no documented evidence that the Administrator participated in two elopement drills for 2022 as required. He did participate in one elopement drill on only. (Photographic Evidence Obtained) On at 4:10 PM, an interview with the Administrator and the Maintenance Director confirmed the findings. Class III	A 032		

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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 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	A 078		

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A 078	Continued From page 5 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 personnel record review and interview, the facility failed to obtain documented evidence for 1 of 4 sampled staff (C) submitted a one-time statement they are free of communicable . . . . . within 30 days of employment and failed to ensure the personnel record for 1 of 4 sampled staff contained documented evidence of a negative . . . . . (. .) examination on an annual basis (A). Findings: 1. Review of caregiver C's record revealed a hire	A 078		

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A 078	Continued From page 6 date of . . . . There was no documented evidence of the Communicable statement. 2. A review of caregiver A's personnel record revealed a hire date of . The record contained a . . . . written statement from a health care provider documenting the caregiver was free of communicable . . . . . The record did not contain documented evidence of a negative . exam annually thereafter. On . . . . . at 5:35pm Human Resources confirmed the findings and provided no additional documentation. Class III	A 078		
A 080 SS=D	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities.	A 080		

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A 080	Continued From page 7 (b) Resident rights and identifying and reporting , neglect, and , . (c) Special needs of elderly persons, persons with mental illness, and persons with , and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with 's and related . 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , , , and managers who attended the core training program prior to , , , shall not be required to take the competency test. Administrators licensed as nursing home	A 080		

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A 080	Continued From page 8 administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that the Administrator completed 12 hours of continued education in topics related to assisted living facilities every 2 years as required. Findings: Review of the Administrator's personnel record revealed a hire date of . . He completed his 26 hours CORE assisted living classroom training on and successfully passed the CORE examination on . The last 12	A 080		

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A 080	Continued From page 9 hours of continued education training completed was on . There were no 12 hours of continued education training in topics regarding to assisted living completed in 2022 or 2023 in the file. On at 4 PM, an interview with the Business Office Manager confirmed the findings. Class III	A 080		
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.	A 081		

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A 081	Continued From page 10 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 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.	A 081		

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A 081	Continued From page 11 (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 . . . 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.	A 081		

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A 081	Continued From page 12 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that 2 of 4 sampled staff (B & C) completed 2 hours preservice orientation training that must cover facility type, and services offered by the facility signed by the employee and signed by the Administrator prior to interacting with the residents. Findings: 1. Med Tech B's personnel record review revealed a hire date of .. .. There was no documented evidence that the 2 hours preservice orientation training was completed in the file. On .. .. at 4:20 PM, an interview with the Business Office Manager confirmed the findings. 2. Review of caregiver C's record revealed a hire date of .. .. There was no documented evidence of the 2-hour pre-service orientation statement signed by the administrator and staff. On at 5:35pm Human Resources confirmed the findings and provided no additional documentation. Class III	A 081		

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A 084	Continued From page 13	A 084		
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 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 . . . . 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:	A 084		

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A 084	Continued From page 14 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] and 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 reactions to medications and report such reactions; h. Assist residents with [illegible] syringes that are prefilled with the proper dosage by a pharmacist and [illegible] 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 [illegible]; j. Use a [illegible] to perform [illegible] testing; k. Assist residents with [illegible] and continuous positive airway pressure (CPAP) devices, excluding the titration of the [illegible] levels; l. Apply and remove [illegible] stockings and hosiery; m. Placement and removal of [illegible] bags,	A 084		

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	AL11968966	A. BUILDING: _____ B. WING _____	09/19/2023

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A 084	Continued From page 15 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 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 personnel record review and interview, the facility failed to obtain the initial 6-hour	A 084		

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A 084	Continued From page 16 medication training for 1 of 1 sampled staff (C) prior to assisting with self-administration of medication. Findings: Review of caregiver C's record revealed a hire date of . There was no documented evidence caregiver C received the initial 6-hour training for self-administration of medication. On at 5:35pm Human Resources confirmed the findings and provided no additional documentation. Class III	A 084		
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	A 093		

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A 093	Continued From page 17 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. 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.	A 093		

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A 093	Continued From page 18 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 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	A 093		

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A 093	Continued From page 19 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 observation of the facility's menu and interview, 1. the facility failed to obtain the licensed or registered dietician with license credential number listed on the annual approved menu; 2. the facility failed to provide menus dated planned in a week advance; 3. the facility failed to provide the documented substitute log of comparable nutritional value used for the past 6 months and; 4. conspicuously post approved menus in the memory care for residents can have an opportunity to review. Findings: An observation on . . . . . at 11:50 AM, a week one spring and summer menu posted outside the assisted living dining room on the wall upon entrance. The menu was not dated a week in advance and the registered dietician signed and dated the menu but did not list her licensed credential number. An observation on . . . . . at 12:10 PM that there were no menus posted at all in the Memory Care east wing and west wing dining rooms where the residents can easily review. There was no documented evidence of the last 6 months of substitution logs as required. (Photographic Evidence Obtained) On . . . . . at 12:30 PM, an interview with the Administrator stated the Food Manager was out	A 093		

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A 093	Continued From page 20 sick and was not answering his phone to locate the completed substitution log. The Administrator confirmed all the findings. Class III	A 093		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside	A 152		

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A 152	Continued From page 21 commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . . . . . . This Statute or Rule is not met as evidenced by: Based on observations and interviews the facility failed to provide a safe living environment free of hazards. Findings: Observations made on revealed what appeared to be a water-like stain in the ceiling in . The water-like stain was located directly above the resident's recliner and what also appeared to be a repaired stain above the residents' bed. On . . . . . at 10:42am Resident #6 stated he has informed the Administrator that the roof leaks in his room every time it rains. Resident stated he has the bucket sitting next to his recliner to catch the rain. The resident stated the Administrator just documents it, says he will get it fixed, and they need a new roof. Resident stated he has been here about months. The resident stated the spot over the bed appears to have been repaired before he moved it. On a record review of resident #6 admission date . . . . . revealed the resident has been residing in the facility for five months. On at 4:25pm The Administrator stated there is an issue with the roof. We have a quote that in two weeks to have repaired. The	A 152		

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A 152	Continued From page 22 Administrator stated we have reached out to other roofing companies and received several quotes. We're told that the last company used the wrong dormers and now other companies won't touch them. On . . . . . at 4:25pm The Administrator stated if we have heavy rain, and the wind blows sideways the rain is able to come under the roof. The Administrator stated it has been leaking for . months in different areas. On . . . . . at 4:25pm The Administrator stated I don't believe it was leaking prior to resident #6 moving in. On . . . . . at 4:25pm The Administrator stated resident # , have spoken with the Assistant Executive Director. The Administrator stated I personally have not spoken with resident #6. On . . . . . the facility's grievance log was reviewed, and no documentation was found for resident #6's complaints regarding the roof leak in his apartment. The facility's Complaint - Grievance policy effective date . . . . . states, "The Executive Director is responsible for assuring the Complaint-Grievance policy is in place. Residents are encouraged to discuss any complaint or grievance promptly with the Executive Director. The Executive Director will ensure a log is kept to document each grievance to include the date reported and resolved, nature of grievance, summary of meetings, individual involved and resolution. The Executive Director should follow up after the resolution is in place to assure the plan of correction is successful."	A 152		

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A 152	Continued From page 23 On at 4:30pm The Maintenance Director stated we do rounds and check all that stuff. I have a list with a couple of areas that have leaks. On at 4:30pm The Maintenance Director stated we had a contract that we signed about 3 months ago. The company recently stated they no longer could do the work. On at 4:30pm The Maintenance Director stated we have a new contract signed on and the work will begin in about 1 and a half weeks. On at 4:48pm The Administrator observed the spot in resident #6 room and stated there's no stain it's been repaired. On at 4:58pm The Maintenance Director stated the list they have dated indicates was a stain in . On at 4:58pm The Maintenance Director provided a 3-page list dated including room #'s from 300 - 327 with their status. listed indicates "ceiling stain room". On at 4:58pm The Maintenance Director stated resident #6 would not have been moved into the room if she was aware of the leak in . On at 5:32pm The Maintenance Director stated her maintenance team went through today with the list to repair the stains.	A 152		

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A 152	Continued From page 24 On . . . . . at 5:32pm The Maintenance Director provided several work order reports which indicate . . . . ceiling is leaking where repairs were done . . . . The second work order dated . . . . . , apartment 303 states paint is chipping from the ceiling tiles on to his bed and near front door. On . . . . . at 5:32pm The Administrator and Maintenance Director confirmed the findings. Photographic Evidence Obtained Class III	A 152		
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 25 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 personnel record review and interview, the facility failed to ensure that 2 of 4 sampled staff (B & C) signed a job description required for an assisted living facility with a licensed capacity of 17 or more residents. Findings:	A 161		

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A 161	Continued From page 26 1. Med Tech B's personnel record review revealed hire date . . . . . There was no job description signed in the file. On at 4:20 PM, an interview with the Business Office Manager confirmed the findings. 2. Review of caregiver C's record revealed a hire date of . . . . . There was no documented evidence of the job description. On at 5:35pm Human Resources confirmed the findings and provided no additional documentation. Class III	A 161		