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
	AL11969626	A. BUILDING: _____ B. WING _____	11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRIVE AT FERN PARK	7255 STRIVE PL FERN PARK, FL 32730

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A 000	Initial Comments Two Complaint Investigations #2023012159 and #2023015120 were conducted at Strive at Fern Park Assisted Living Facility and Memory Care on [redacted] and [redacted]. The facility had deficiencies at the time of the survey visit.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

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A 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide care and services appropriate to meet the needs for 1 of 3 sampled residents by failing to provide adequate supervision and ensure safety through proactive measures to minimize the potential for injuries (#3). Findings: Observations and interviews revealed the following: On at approximately 9:30am resident	A 025		

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A	Continued From page 2 #3 was observed in the hallway with what appeared to be -like markings around his left and alongside his left upper cheek. The resident stated he was beat up by a man and a lady. On at 12:30pm The Administrator stated 2 Visitors signed the visitors log to visit resident #9 but instead visited resident #3. The administrator stated the visitors were introduced to resident #3 by resident #9. The visitors allegedly let resident #3 use their wheelchair and returned to retrieve it. Review of the facility's Sign In/Out Visitors log dated revealed visitor #1 signed in at 1:09pm and visitor #2 signed in at 1:13pm. Both signed out at 3:05pm and identified resident #9 as the resident they were visiting. On at 4:03pm Resident #9 stated she informed visitor # can't come in. Resident #9 stated I did not know visitor #1 was coming. Resident #9 stated I didn't know anything about the incident between resident #3 and the visitors. On at 4:13pm Resident #3 stated "since I got beat up it changed. I was perfectly fine. I do my own meds and go to the bathroom by myself before I get beat up. I was totally independent up until today. I used to walk 5 times a day." On at 4:29pm interview with Staff C noted resident #3 usually can walk and get in his chair. Staff C stated they were not present when the incident happened but heard the next day from resident #9 who told her resident #3 got beat up by visitor #2 who came for his wheelchair. Staff C stated the housekeeper	A 025		

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A 025	Continued From page 3 opened the door and let visitor #2 in. and that Visitor #2 went in and threw resident #3 down and beat him up. A facility note by Staff K on reads, "I was walking by resident #3's room and saw staff L open resident #3's room door for a guy (visitor #2). He (visitor #2) then proceeded to push his way into the room where resident #3 was and went around resident #3 and took the chair and proceeded to the door. Resident #3 then tried to the door so he could not get out and the visitor managed to get out the door with the chair. Once the door was open resident #3 was on the floor." On at 1:20pm, a phone interview with Staff K was conducted. Staff K stated the guy (visitor #2) got in the room and resident #3 blocked the door with his wheelchair. Then resident #3 put his out so the guy couldn't get out, but the guy got the door open, and I saw resident #3 on the floor. By the time Staff N came we got resident #3 off the floor and put him in the wheelchair. Resident #3 stated the guy kicked him in the when I was on the floor. Resident #3 then went to the front desk to report it. The couple went to the front area by the bistro and waited for the cops to come. I had seen the couple once before interacting with resident #3. A facility note by Staff L on reads, this man (visitor#2) asked me to open the door of resident #3 (who is in good shape) and I was thinking that he is a relative and he opened the door for him. When resident #3 comes in he tells the visitor to leave. They start arguing and I call my Staff M to intervene with the situation. On at 1:26pm, a phone interview with	A 025		

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A 025	Continued From page 4 Staff L was conducted along with Staff Q who was the translator for Staff L. Staff L stated usually resident #3 has his door open and I was surprised that the door was closed. The man (visitor #2) asked me to open the door. I thought something bad happened. So, when visitor #2 asked to open the door. I thought he was a family member. The man (visitor #2) stated nicely to resident #3. I just came to pick up the wheelchair. Then resident #3 started screaming, go, go, go, get out of here. When I saw resident #3 out of control, I called Staff M on the phone, and he came fast. I was outside the door and with the 2 nurses Staff K and Staff N. Staff M came and he went inside. I observed resident #3 on the floor. I think Staff M helped resident #3 off the floor. Resident #3 started saying help, help, and the visitors waited outside the room. I was standing near the exit door when the couple (visitor #1 and #2) left resident #3's apartment. They went to resident #9's apartment and told them I got your wheelchair but did not leave the wheelchair with her. A facility note by Staff M on . . . . . reads, Staff L called me stating that there was a fight in apt 119 Biltmore. When I got there, I saw resident #3 on the floor and I let the staff O and Staff P know. On at 12:33pm Staff M stated during the interview that Staff L called me on the phone, and I went there to resident #3's apartment and saw the couple (visitor #1 and #2). I told visitor #1 and #2 not to leave. I left the apartment to let Staff O, and Staff P. I think one of them called the cops but I'm not sure. I had never seen visitor #1 or visitor #2 before. Staff P started walking . . . towards the room. On at 1:03pm Staff O stated during the	A 025		

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A 025	Continued From page 5 interview, I was sitting at the front desk when Staff M came running to the desk. Staff O stated staff M said resident #3 got beat up and laying on the floor and made the call to the police. I went to tell Staff P and she went to the room. A facility note by Staff N on . . . . . read, I didn't witness the fight, but I did see them both arguing and calling each other names. Someone from the outside. I was told resident #3 . out of his chair. He has a knot on his forehead." On at 1:09pm during a phone interview with Staff N she stated I think one of the housekeepers let visitor #1 and visitor #2 in. I was passing meds and of the co-workers (Staff K) told me they were fighting. I went around there and saw resident #3 roll up on visitor #2 in his wheelchair. I heard visitor #2 state if you roll up on me again. I'm going to beat your a--. I didn't witness inside, just the outside event. I heard visitor #1 tell visitor #2 to come on its not worth it. They left and I saw them up front by the bistro. A facility note by Nurse I on read, was called to resident #3's apartment. Upon arriving at the apartment. Resident #3 and outsiders (visitor #1 & visitor #2) were arguing. The resident door was partially closed, and he yelled help. Went into the resident apartment and the resident was on the floor. Nurse, I stated Staff K helps me get resident off the floor. Resident then came after the outsider yelling at him. The two were arguing and Resident #3 came to nurse station and 911 was called. Resident had to Left , right small , a bump to Left side of forehead,	A 025		

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A 025	Continued From page 6 to Left , and a to Left ." A facility note by Nurse I on at 9:53am read, "On Resident was on floor upon this writer entering the room, he has to left , right small , and left , has a bump on left side of forehead. Resident was sent out hospital." A facility note entered by the Director of Nursing (DON) on at 10:47pm read, "Resident returned to the community at approximately 8pm from the hospital via son. Resident observed in his bed at approximately 9:45pm. Resident was noted to have to left , left , covered with bandages from the hospital, a to right fifth , and a golf ball size bump on left side of forehead and above left noted to right and scratch to left . Resident denied , but stated he was " all over". Resident was assisted in bed by care staff." On at 5:45pm The Administrator provided documentation from visitor #2 of the event which states on at 9:28 am, "After saying hello to resident #3 in the lobby, Visitor #1 and I walked with resident #3 (he was in his own wheelchair) to resident #9's room. I waited in the area between resident #3 and resident #9's room. Visitor #1 visited resident #9 and resident #3 went to his room. In a couple minutes, I knocked loudly on resident #3's door, at least 3 times, then asked a staff member to unlock it, which she politely did. I knocked on the door twice and slowly walked in, taking steps. I thought it was all friendly. Resident #3 was in his wheelchair, with his to me. I politely asked him for visitor #1's wheelchair and he immediately	A 025		

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A 025	Continued From page 7 turned around and came directly at me fast forward, throwing boxes at me and yelling f--- you it's my chair and get the f--- out. Both resident #3 and I were yelling and resident #3 threw his chair at me that left a bloodied and . Visitor #1 came in and resident #3 purposely out of his wheelchair and purposely banged his on the floor, screaming. I pushed him and saw him kick Visitor #1 in the , knocking her backwards, and resident #3 kicked me in the left , screaming that I hit him. I grabbed his then kneeled my right on his right , trying to keep resident #3 down to protect myself and visitor #1. Never did I push, bump, hit, punch, , kick or do any aggressive physical act towards resident #3." Review of the facility's undated , Neglect, and , Policy states, "It is the policy of this facility to protect its residents from , neglect, and , providing a safe and protected environment. Employees who witness acts of , neglect, or , are required to report them immediately." On at 5:45pm The Administrator stated they did not follow their policy by keeping resident #3 safe. The Administrator confirmed that the housekeeper opened the door, allowing the 2 visitors in resident #3's room where the incident occurred and resident #3 was injured. Class II	A 025		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of	A 052		

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A 052	Continued From page 8 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 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 052		

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A 052	Continued From page 9 (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (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 18	A 052		

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A	Continued From page 10 , ... g . or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with 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	A 052		

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A 052	Continued From page 11 organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of 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 interviews the facility failed to ensure 1 of 1 sampled resident received assistance with self-administration (#3). Findings: Observations made on at 4:12pm found unsecured OTC (over-the-counter) medications throughout resident #3's room. The medications consisted of vapor rub, High , ZZZ Quil Pure ZZZZ, High , Refresh Optive, drops, A-D, and Super Beets gummies. The medications were found on resident #3's nightstand and kitchen counter. On at 4:12pm Resident #3 stated I do	A 052		

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A 052	Continued From page 12 my own meds. On at 5:45pm The Administrator stated resident #3 does his own meds. A physician order dated states, "Patient to self-administer medications with adaptive jars or pre-packaged prescriptions after medication identification." Review of resident #3's health assessment (1823) revealed he needs assistance with self-administration. On at 5:45pm Review of resident #3 Medication Observation Record (MORs) for , listed self for administration of all medications. On at 5:45pm The Administrator removed from resident #3 room's prescription medications , , , , , , Chlor Neb, , / , /M-Dry 1, , 500 mg (2 bottles), , 250 mg, CL ER 10 MEQ (3 bottles), 5 mg Tab (3 bottles), Rosuvastatin 10 mg Tab (2 bottles), Rosuvastatin 20 mg Tab, , 81 mg Tab (2 bottles), , , 75 mg Tab (2 bottles), , ER (SUCC) 25 mg (2 bottles), 20 mg Tab, and , 25 mg Tab. The additional OTC medications are softener, Spray, 2 bottles of Benefiber, , (2 bottles) & chewables, liquid gels, Destin, Align Probiotics, Breathe Right Strips, HBP tablets, No 3 Chrome Capsules, Qunol Ultra CoQ10 soft gels, Mega Men capsules, D3 supplements soft gels, Sildenafil Tablet, and pre-filled pill organizer.	A 052		

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A 052	Continued From page 13 On at 6:00pm The Administrator stated she was unaware that resident #3's current 1823 stated he required assistance with self-administration. 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 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	A 054		

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A 054	Continued From page 14 429.41, 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, record review, and interviews the facility failed to ensure 1 of 1 sampled resident received assistance with self-administration (#3). Findings: Observations made on at 4:12pm found unsecured over-the-counter OTC medications throughout resident #3's room. The medications consisted of vapor rub, High , ZZZQuil Pure ZZZZ, High , Refresh Optive, drops, A-D, and Super Beets gummies. The medications were found on resident #3's nightstand and kitchen counter. On at 4:12pm Resident #3 stated I do my own meds. On at 5:45pm The Administrator stated resident #3 does his own meds. A physician order dated states, "Patient to self-administer medications with adaptive jars or pre-packaged prescriptions after medication identification." Review of resident #3's health assessment (1823) revealed he needs assistance with self-administration. On at 5:45pm Review of resident #3 Medication Observation Record (MORs) for , , , , listed self for	A 054		

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A 054	Continued From page 15 administration of all medications. On [redacted] at 5:45pm The Administrator removed from resident #3 room's prescription medications [redacted] Chlor Neb, [redacted] /M-Dry 1, [redacted] 500 mg (2 bottles), [redacted] 250 mg, [redacted] CL ER 10 MEQ (3 bottles), [redacted] 5 mg Tab (3 bottles), Rosuvastatin 10 mg Tab (2 bottles), Rosuvastatin 20 mg Tab, [redacted] 81 mg Tab (2 bottles), [redacted] 75 mg Tab (2 bottles), [redacted] ER (SUCC) 25 mg (2 bottles), [redacted] 20 mg Tab, and [redacted] 25 mg Tab. The additional OTC medications are [redacted] softener, [redacted] Spray, 2 bottles of Benefiber, [redacted] (2 bottles) & chewable, [redacted] liquid gels, Destin, Align Probiotics, Breathe Right [redacted] Strips, [redacted] HBP tablets, No 3 Chrome Capsules, Qunol Ultra CoQ10 soft gels, Mega Men capsules, D3 supplements soft gels, Sildenafil [redacted] Tablet, and pre-filled pill organizer. On [redacted] at 6:00pm The Administrator stated she was unaware that resident #3's current 1823 stated he required assistance with self-administration. 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	A 055		

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A 055	Continued From page 16	A 055		

prescription and over-the-counter, in their 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

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A 055	Continued From page 17 by keeping the area in which the refrigerator is 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	A 055		

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A 055	Continued From page 18 dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observations, record review, and interview the facility failed to maintain a list of all medications which includes over the counter (OTC) of 1 of 1 sampled resident was kept secured and out of sight or disposed upon expiration. Findings: Observations made on at 4:12pm found unsecured OTC medications throughout resident #3's room. The medications consisted of vapor rub, High , ZZZ Quil Pure ZZZZ, High , Refresh Optive, drops, A-D, and Super Beets gummies. The medications were found on resident #3's nightstand and kitchen counter. On at 5:45pm The Administrator removed from resident #3 room's prescription medications Chlor Neb, / , and all OTC medications. On at 6:00pm Review of resident #3's medications revealed the following expired 25 mg exp Tab 1 mg exp Chlor Neb 3% exp Tab 250 mg exp , and / exp Review of the facility's dated Self-Administration of Medications policy states, "Strive at Fern Park shall maintain Medication	A 055		

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A 055	Continued From page 19 standards in a manner consistent and in compliance with the minimum standards required by current statute rule. Strive at Fern Park will adhere to the following procedures: Healthcare Providers order must be kept on file in resident record, Wellness staff shall evaluate the resident's ability to self-administer their medications when performing monthly nursing evaluations. A Level of Care assessment form may be used to track this monthly. The Community will consult with the resident on any problems related to medications including adverse reactions, medication management and the resident ability to self-administer medications or not. The Community will contact the resident's Health Care Provider upon any significant change in condition related to medications and document in the resident's record." On at 6:00pm The Administrator confirmed the findings. Class III	A 055		
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.	A 081		

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A 081	Continued From page 20 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 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	A 081		

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A 081	Continued From page 21 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 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.	A 081		

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A 081	Continued From page 22 (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to ensure that 1 of 7 sampled staff (D) completed the 2 hours pre-service orientation training prior to interacting with residents as required. Findings: Caregiver staff D personnel record review revealed a hire date of . . . . . There was no documented evidence that the 2 hours pre-service training was completed covering topics in facility type and services offered in the facility signed by both the employee and signed by the Administrator. The one-hour resident rights training was completed on . . . . . . On , the schedule showed that caregiver staff D was working with the residents	A 081		

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A 081	Continued From page 23 on the 7am-3pm, 1st shift. (Photographic Evidence Obtained) On ..... at 4:45 PM, an interview with the Administrator confirmed the finding. Class III	A 081		