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
	AL11966171	A. BUILDING: _____ B. WING _____	12/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRINGTON TERRACE OF NAPLES	5175 TAMIAMI TRAIL EAST NAPLES, FL 34113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced relicensure, extended congregate care, emergency power plan, health facility reporting system, generator, visitation form, and complaint survey for #2022015670 was conducted on through at Barrington Terrace of Naples, an assisted living facility in Naples, Florida. Complaint #2022015670 was substantiated at A 032. The following is a description of the deficiencies.	A 000		
A 030 SS=D	59A-36.007(5) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (5) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. (b) In accordance with Section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program,	A 030		

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A 030	Continued From page 1 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to Rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . ., neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and standard precautions; 8. The requirements for coordinating the delivery of services to residents by third party providers; 9. Assistive devices; and 10. Physical (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private	A 030		

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A 030	Continued From page 2 communication, pursuant to Section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue	A 030		

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A 030	Continued From page 3 the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , , the guardian shall be	A 030		

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A 030	Continued From page 4 given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local	A 030		

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A 030	Continued From page 5 long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . , ... or . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to post the telephone number for lodging complaints against a facility or facility staff in full	A 030		

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A 030	Continued From page 6 view in a common area accessible to all residents near a telephone accessible by residents. The findings included: On at 9:46 a.m., during a tour of the memory care unit there was no information with telephone numbers for the Long-Term Ombudsman program, the , Rights Florida or the Florida Hotline available to residents, families or staff members posted in the memory care unit. On at 3:16 p.m., the Executive Director verified the required information was not posted in the memory care unit. Class III	A 030		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement	A 032		

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A 032	Continued From page 7	A 032		

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 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.

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A 032	Continued From page 8 (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 observation, record review, and staff interviews, the facility failed to ensure processes were implemented to prevent 3 residents (#15, #21, #12) of 3 reviewed from unsafe and elopement. The findings included: 1. A review of the record for Resident #15 revealed the resident was admitted to the facility on . The admission health assessment (Form 1823) completed on and updated on noted resident #15 was an elopement risk. Resident Diagnoses included or behavioral status included severe short-term memory . A nursing progress note dated 11/16/23 at 9:49 pm documented "resident observed getting out from door" and was redirected to her room. An additional nursing progress note dated indicated resident was observed at 5:15 a.m., prior to being found outside the building as an employee recognized the resident walking east on the sidewalk. Facility investigation noted the resident exited through a fire door which alarmed for 15 seconds. Three staff approached the door, reset the alarm, and closed the open door. Corrective actions included having a staff person supervise the common areas, mandatory elopement	A 032		

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A 032	Continued From page 9 drill/training scheduled for . . . . . Vendor to assess increasing the volume of the door alarm, and internal pull closure on the door. The facility is obtaining an estimate to install a gate on the walkway outside 200 doors exit with a key , . . . No specific interventions were identified on the service plan to decrease the risk of elopement. Facility progress notes documented on . . . . . , Resident #15 was observed to walk out of the secured memory care unit to the parking lot at approximately 6:45 a.m. Facility Licensed Practical Nurse Staff I, observed the resident on the sidewalk as she was driving to work. She pulled over and assisted the resident into her vehicle to return her to the community. The facility Analysis noted that a . . . . count was not completed upon hearing the door alarm sounding. Staff reported "peering" outside and did not see the resident. The alarm mat was off at the end of the door, coaching completed for all staff on unit. Inspection of door noted it functioned with no abnormalities. 2. A review of the record for Resident #21 revealed the resident was admitted to the facility on . . . . . and discharged . . . . . . The admission 1823 noted the resident to be an elopement risk. No interventions were noted on the service plan to decrease the risk of elopement. A nurse Progress Note dated . . . . stated, at "approximately 1530 (3:30 p.m.), this nurse watched as the resident went out the . . . door emergency exit. Resident was almost on the sidewalk of a busy street. When confronted the resident became combative and was threatening bodily harm". Once the resident was returned by staff to the facility, he ran out the door again. The police were contacted, and the resident was transported to a local hospital for	A 032		

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A 032	Continued From page 10 evaluation. " The facility investigation noted the resident was last seen in the living room at 8:11 a.m. Resident #21 was discovered missing at 9:02 a.m., and an area search began at 9:04 a.m. As the search was expanded from inside the building to surrounding establishments, authorities discovered the resident at a local gas station. The resident was transported to the hospital for evaluation. Immediate interventions included 24-hour supervision with a private duty aid and meeting with the power of attorney. The facility analysis of the incident stated ,"it appears the door was not latched when exited, but he was pressing the keypad. It is unclear if he had knowledge of the code to disengage the door or if the door was already disengaged at that time. What we do know is that the door alarm never sounded which means it could only be one of those two scenarios." The facility corrective action summary stated the maintenance director scheduled a contractor to change the door codes and also to service the door to assess its function. Staff in-service was conducted on the nature of the elopement and interventions executed to ensure safety and security including posting staff in a location where there was visualization on exit points at all times, door alarm checking throughout each shift, increasing rounds/ counts throughout each shift. 3. A review of the record for Resident #12 revealed the resident was admitted to the secured memory care unit on . The admission assessment (1823) identified the resident as an elopement risk on . Medical history and diagnoses included	A 032		

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A 032	Continued From page 11 and 's Resident required supervision with ambulation and staff assistance with bathing, grooming, and eating. The Facility investigation noted the resident left the secured memory care unit on at 5:30 p.m. The resident was later located by law enforcement 1.5 miles away from the facility and taken to a local hospital for evaluation prior to return to the facility. Immediate interventions were to place a private duty aid with resident over the weekend. The Facility root cause analysis stated "we have serviced the exit door to confirm proper function. We have replaced the door alarm to ensure new equipment in place. Staff continue training of monitoring the exit doors and counts. On the corrective action identified by the facility included increased monitoring of the exit doors by team during shifts, care conference held with spouse, support network, behavior modification techniques to reduce sundowning behaviors and admission to hospice services. Facility interventions included Staff were re-trained on setting alarm/responding to alarm, elopement drill planning. On at 10:30 a.m. in an interview, the memory care technician said she had been employed for two weeks. The technician said she did not know about elopement, lost, or resident training and she did not know the code for resetting the door alarm On at 2:16 p.m., the Executive Director (ED) said the mandatory drill/elopement training that was scheduled for all staff on after the elopement of Resident #15 on was not done. The staff are expected to always have on each door. They have been coached to	A 032		

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A 032	Continued From page 12 watch the doors to keep the residents safe. The ED said the in-service training on accountability was not completed by all staff. The ED said the estimate for the gate installation on the walkway outside of the 200 halls has not yet been obtained. She said the coaching/training education for night shift involved in the elopement for Resident #15 has not yet been done. On at 3:30 p.m., Licensed Practical Nurse (LPN) Staff I said she stopped her car in the turning lane prior to pulling into the parking lot and recognized Resident #15. She asked the resident to get in the car but the resident was talking "gibberish" and did not make sense. The resident proceeded to walk toward the of the staff person's car, so the staff person parked the car and assisted the resident into the car and notified the Resident Care Director. She said staff in the memory care unit did not know the resident was missing, they last saw her sitting in the hall. They did not call for an elopement search. On at 6:35 a.m., two staff members were observed assisting residents and two staff were observed in the medication room counting medications. The night shift 2-hour check form was incomplete. (photo documentation obtained). On at 6:40 a.m., the Maintenance Director said he does not have any notes, emails, or estimates for the planned gate but will call the company today and requires their quote. On at 6:41 a. m.-7:04 a.m., No staff members were observed in the hallways or observing the exit doors.	A 032		

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A 032	Continued From page 13 On … … … at 6:55 a.m., Staff K said, "we are supposed to rotate checking the halls, I was doing paperwork". On … … at 7:04 a.m., the memory care medication technician stated she has not had elopement training since starting work at the facility weeks ago. She said we check the residents often, noting their whereabouts. She said she did not know which residents were considered high risk for elopement. On … … … at 8:04 a.m., the maintenance director said the door codes and key access cards have not been changed since he has been employed in the past 6 months. His new hire orientation included computer training. He has not had facility specific training regarding the elopement process or policy. On … … … at 10:00 a.m., the Resident care director said the 200-hall door had a "screamer alarm" installed last week. Resident #15 was able to leave through the door which was closed but not re-armed. The door must be securely closed, and the alarm may need to be entered twice and the check mark pushed to clear the alarm code at the front desk. On at 12:24 p.m., the new employee orientation agenda was provided by the ED. Preservice orientation included computer training of 30 minutes about responding to elopements.	A 032		
A 033 SS=D	59A-36.007(8) PHYSICAL (8) PHYSICAL . Residents for whom a physician has prescribed a physical … must have a written care plan for the use	A 033		

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	AL11966171	A. BUILDING: _____ B. WING _____	12/21/2023

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A 033	Continued From page 14 of the physical . . . . . . The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. (a) The care plan must specify: 1. The device prescribed for use; 2. The maximum amount of time the resident is to have the . . . . applied each day; and, 3. In what manner and frequency staff will monitor, observe, and report to the physician any injuries, increase in agitation, signs and symptoms of . . , ... , or decline in mobility or function related to the use of the prescribed . . . . . . (b) Facility staff must ensure that the device is applied appropriately and safely. (c) The resident's physician must review the appropriateness of the continued use of the physical annually, and documentation of this review must be maintained in the resident's record. If the resident's ability to independently remove or avoid the device fluctuates, the device must be considered a physical and all requirements of this subsection apply. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure physician orders and care plans were established for 3 (Residents #14, #18, #19) of three residents reviewed for . The Findings Included: The Facility policy titled " -Florida"; last reviewed . . . . . was provided. The procedure stated, "Residents will be free of extended involuntary . . . . . and from physical and chemical ... . may not be used in lieu of staff supervision or merely for staff convenience ..."	A 033		

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A 033	Continued From page 15 On at 9:48 a.m., Residents 14, 18 and 19 were observed sitting in recliners in the "Namaste" Room with a half door closed. All three recliners had the footrest elevated. No staff had visibility of the residents in the room. On at 10:37 a.m., LPN Staff I verified she was familiar with the three residents and all three had advanced . The three residents were sitting in recliners with the footrest elevated by a handle on the side of the chair. Staff I verified the three residents were not able to reposition themselves or lower the footrest using the arm on the chair due to their advanced . None of the three residents were able to answer any questions. Staff I said the residents were placed there for their comfort rather than sleeping in their wheelchair where they could . On at 10:30 a.m., Certified Nursing Assistant Staff H said she did not know if she has had training or training on assistive devices and since starting work at the facility two weeks ago. On at 11:30 a.m., the Executive Director said they were not aware the recliners were functioning as a and would look into other options for the residents. Class III	A 033		
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	A 078		

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A 078	Continued From page 16 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 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	A 078		

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A 078	Continued From page 17 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, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that within 30 days of employment staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable . . . . . and evidence of freedom from ( ) documented annually thereafter for 2 (Staff D, and Administrator) of 4 employee records reviewed. The findings included: Review of Staff D's file revealed a hire date of . . . . . as a Resident Aide/Medication Technician. Staff D's file contained documentation of a . . . . . Skin Test Disclosure and Consent Form, with a test completed on and read	A 078		

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A 078	Continued From page 18 on . . . . . Staff D's file contained no evidence of a statement from a healthcare provider indicating Staff D was free from signs/symptoms of a communicable . The Administrator's file revealed a hire date of . . . . . The Administrator's file contained documentation of a note dated , and . . . . . that indicated the patient has had her required , and was found to be free. The statement had no signature from the physician and did not indicate the administrator was free from signs and symptoms of communicable . On at 3:10 p.m., the Business Office Director acknowledged the findings. Class III	A 078		
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.	A 081		

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A 081	Continued From page 19 (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 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,	A 081		

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A 081	Continued From page 20 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. (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	A 081		

Agency for Health Care Administration

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A 081	Continued From page 21 within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure facility employees complete 2 hours of preservice orientation prior to interacting with residents and in-service training required by Florida Administrative Code within 30 days of employment for 3 (Staff D, E, and F) of 4 employee files reviewed. The findings included: On . . . . . , record review of Resident aide/Medication Technician Staff D, Resident aide/Medication Technician Staff E, and Resident Aide Staff F revealed the following: Staff D's file revealed a hire date of as a Resident Aide/Medication Technician. Further review of Staff D's file revealed on Staff D completed 30 minutes of Preventing, Recognizing and Reporting . The regulation requires completion of 1-hour of training. On . . . . . Staff D completed Advanced Care Planning	A 081		

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A 081	Continued From page 22 Conversations. There was no documentation of completion of 1 hour of training and Elopement Response training. Staff E's file revealed a hire date of . . . . . as a Resident Aide/Medication Technician. Further review of Staff E's file contained no documentation of completion of 2 hours of preservice orientation prior to interacting with the facility residents. Staff E's file contained no documentation of completing a minimum 1 hour in-service in: Incident Reporting training, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, or 3 hours in services training for: ADL and Behavioral needs within 30 days of employment. Staff E completed on . . . . . online 30 minutes of Managing Elopement through Relias which was not specific to the facility Elopement policies and procedures. Staff E completed on online 30 minutes of Preventing, Recognizing and Reporting through Relias which was not specific to facility polices. Regulation requires 1 hour of training to be completed. Staff E's file contained completion certification for . . . . . 's Level I on . There was no agenda documentation to indicate what topics was included with the training. Staff F's file revealed a hire date of as a Resident Aide. Further review of Staff F's file revealed documentation of completing 30 minutes of Managing Elopement training on , through Relias online training which was not specific to the facility polices for Elopement. Staff F completed 30 minutes of Preventing, Recognizing and Reporting . . . . . on . . . . , regulation requires 1 hour of training. Staff F's file contained no documentation of completion of Reporting Major Incidents, Reporting Adverse	A 081		

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A 081	Continued From page 23 Incidents, Facility Emergency Procedures, and Incident Reporting Training. On at 3:10 p.m., the Business Office Director confirmed the findings, and acknowledged the certificates were not valid as they did not meet the regulation requirements. Class III	A 081		
A 090 SS=D	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 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 record review and interview, the facility failed to ensure facility employees complete at least one hour of training in the facility's policies and procedures regarding ( ) within 30 days after employment and maintain documentation of completion for 3 (Staff D, E, and F) of 4 employee files reviewed. The findings included:	A 090		

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	AL11966171	A. BUILDING: _____ B. WING _____	12/21/2023

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A 090	Continued From page 24 Record review of Staff D's employee file revealed a hire date of . . . . . as a Resident Assistant/Medication Technician. Staff D's file contained documentation of having completed an in service on Advanced Care Planning Conversation on . . . . . There was no evidence of completion of in-service on . . . . . (. . . .). Record review of Staff E's employee file revealed a hire date of as a Resident Assistant/Medication Technician. Staff E's file contained no evidence of having completed an in service on . . Record review of Staff F's employee file revealed a hire date of as a Resident Assistant. Staff F's file contained no evidence of having completed an in service on . On at 3:10 p.m., the Business office director confirmed the findings. Class III	A 090		
AE210	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING. (a) The administrator and ECC supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility receiving its ECC license or within 3 months of beginning employment in a currently licensed ECC facility as an administrator or ECC supervisor. Successful completion of the assisted	AE210		

Agency for Health Care Administration

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AE210	Continued From page 25	AE210		

living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to , , . . . , shall not be required to take the assisted living facility core training competency test.
(b) The administrator and the ECC supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , or social needs of frail elderly and persons, or persons with 's or related .
(c) All direct care staff providing care to residents in an ECC program must complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address ECC concepts and requirements, including statutory and rule requirements, and the delivery of personal care and supportive services in an ECC facility.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure 1 (ECC Supervisor) of 1 staff reviewed had the required 26-hour core training for an Extended Congregate Care (ECC) licensed facility.

The findings included:

During an interview on at 9:15 a.m., the Administrator stated that the Health and Wellness Director was the designated ECC Supervisor.

Review of the ECC documentation on showed the ECC Supervisor did not have documentation of the required 26 hours of core training as a prerequisite for ECC training.

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	AL11966171	A. BUILDING: _____ B. WING _____	12/21/2023

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AE210	Continued From page 26 During an interview on at 2:30 p.m., the Business Manager confirmed they did not have documentation of the required core training for the prerequisite prior to ECC training. Class III	AE210		