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
	AL11968916	A. BUILDING: _____ B. WING _____	12/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSHORE MEMORY CARE	1260 CREEKSIDE BLVD E NAPLES, FL 34109

(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, emergency power plan, extended congregate care, health facility reporting system, generator, visitation form, and complaint survey for #2022008047, 2022016953, and #2023001288 was conducted on through at Bayshore Memory Care, an assisted living facility in Naples, Florida. Complaint #2022008047 was substantiated at A 025. Complaint #2022016953 was unsubstantiated. Complaint #2023001288 was unsubstantiated. The following is a description of the deficiencies.	A 000		
A 025 SS=D	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 or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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 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.	A 025		

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A 025	Continued From page 1 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 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 observation, record review, review of the facility's policies, staff, and resident representative interview, the facility failed to implement a systematic approach to identify risk factors and implement appropriate interventions	A 025		

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A 025	Continued From page 2 to prevent avoidable [illegible] and [illegible] related injuries for 2 residents (#7, #11) of 3 residents reviewed for [illegible]. Facilities must offer personal supervision to residents as necessary to meet the needs for each resident. The findings included: The Health and Wellness [illegible] Response Guideline issued [illegible], last revised on said Senior Lifestyles is committed to minimizing resident [illegible] and/or injury ... Proper response to [illegible] is part of this process including staff response and investigation for causative reasons/contributing factors. The procedure identified included "obtain statement from any staff involved: "implement Temporary Service Plan for [illegible] (including interventions) ... The "Post [illegible] Investigation Tool "identified specifics of the [illegible] including resident interview, environmental factors including water on the floor, [illegible], improper bed [illegible], improper footwear, call light within reach, behavioral factors included increased agitation, memory [illegible], [illegible], change in sleep pattern, sundowning, [illegible]. The Health and Wellness Director (HWD) will complete investigation and post [illegible] tool. Factors which may have contributed to the [illegible] and interventions implemented would be documented in the Post [illegible] Investigation Tool. The form titled "Temporary Service Plan- [illegible]", provided space for documentation of injuries from recent [illegible], identified "what to chart", Instructions to give to caregivers or Med Aide and Temporary	A 025		

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A 025	Continued From page 3 Service Plan Resolution. 1. Resident #7's record review revealed the resident was admitted to the facility on . Diagnoses included 's or Behavioral Status included agitation, sundowning ... The Resident Health Assessment dated indicated no current physical limitations-reassess if needed. On at 1:29 p.m., the Health and Wellness Director (HWD) said Resident #7 had an unwitnessed , on at 11:30 p.m. Progress notes documented Resident #7 was found supine in the hallway next to . Emergency Medical Services were called and the resident was then transferred to a nearby center. Resident #7 was diagnosed with hematoma, and orbital (,) and , (jaw) . The HWD said there was no documentation when the resident returned on of new or changed interventions, no changes to the service plan, and no Post Investigation Tool was completed. The HWD said progress notes documented; Resident #7 had an unwitnessed on at 12:36 p.m., and was found with a to the right forehead area. The resident was admitted to the hospital for monitoring of a hematoma. Resident #7 returned to the facility on . The HWD confirmed there was no documentation of a post investigation tool, increased supervision, or updated care plan. The HWD said Resident #7 on and was admitted to the hospital for evaluation of a to the . HWD said there was no documentation of changes to the service plan, no changes to the level of supervision, or completion	A 025		

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A 025	Continued From page 4 of a post . risk investigation tool. The facility Service plan dated . . . . . noted, "Resident #7 is independent with mobility/ambulation; Resident #7 does not require assistance with escorting; Resident #7 does not require assistance with transferring." Under the category of potential, the service plan stated, "Monitor resident for . . and report to appropriate Caregiver team members". The HWD reported resident #7 on and was admitted to the hospital until she returned on at 8:34 p.m. There was no documentation regarding the cause of the , updated interventions, changes to the service plan, increased level of supervision or completion of the post investigation. The HWD reported Resident #7 had an unwitnessed . on . . . . . at 7:45 a.m., another on in the evening, and again on . . . . . at 7:19 a.m. from her wheelchair. There was no documentation of increased supervision, service plan updates or completion of the post . investigation. The HWD reported Resident #7 in her bathroom while being assisted by a caregiver on . at approximately 1:00 p.m. Resident #7 attempted to stand up, lost balance and . hitting her . . The HWD verified the resident was not able to transfer herself on or off the toilet and agreed if the caregiver was in the bathroom with the resident, she would have assisted her to transfer. The HWD said there was no post investigation, no interview or documentation with the caregiver assigned to the resident. On at 12:23 pm the HWD verified no	A 025		

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A 025	Continued From page 5 post investigations were completed for Resident #7 or #11. On at 1:30 p.m., the Administrator stated for every we do our internal incident report, put steps in place to help prevent or decrease the number of and update the care plan. The Administrator said the HWD should have completed the report and reviewed them with the Administrator. She confirmed no post reports have been documented or reviewed for Residents #7 or #11. A tour of Resident #7's room found the bed to have been left in a raised position, no mats were in the room. 2. Review of Resident #11's records found the Medical Assessment - Form 1823 noted the resident was admitted to the facility on . Resident #11's diagnoses included with Behavioral Disturbances, Gait disturbances. Resident #11 Service Plan activated noted: Resident required a wheelchair and on assistance by staff members for mobility/ambulation; Resident #11 is dependent on staff for all escort needs and requires the assistance of two people for transferring. " history noted to observe resident is embracing safety measures to decrease potential. (PERSONALIZE)." On at 10:21 a.m., the HWD said Resident #11 was admitted to the facility on and discharged . Recounting incidents, the HWD said facility documentation noted Resident #11 was found on the floor on at 4:15 p.m. The resident bit her bottom , and sustained a cut/ . There was no documentation of implementation	A 025		

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A 025	Continued From page 6 of increased supervision or prevention interventions. The HWD said on at approximately 2:00 p.m., and at 6:14 p.m., Resident #11 was found on the floor. The resident was walking in the hallway and . There was no documentation of interventions to increase supervision, update service plan or refer to , for safety. The HWD said Resident #11 had an unwitnessed on at 5:51 p.m. hitting her . She was transferred to the hospital by Emergency Medical Services and received 10 for a 7 cm to her . Resident #11 returned to the facility the next day. The HWD said documentation noted Resident #11 was observed on the floor on at 1:23 p.m. The resident was assisted to stand and was noted to require stitches to an open area above the left , . Details of the or changes to supervision or service plan were not documented. The HWD reviewed a progress note which read on at 3:21 resident was observed on the floor, "bump to (right) side of forehead and to the right . The resident was treated at the hospital and returned the same day. There was no documentation of implementation of increased supervision or prevention interventions. The HWD reviewed a progress note dated at 12:53 p.m., Resident #11 was walking briskly in the hallway and . She has a over the left , and was transported to the local hospital for evaluation and treatment. There was no documentation of implementation of increased supervision or prevention interventions. The HWD reported Resident #11 had a witnessed on at 1:02 p.m. Resident #11 hit the corner of the wall causing a of the forehead. She was transported to the local hospital for evaluation and treatment. There was	A 025		

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A 025	Continued From page 7 no documentation of implementation of increased supervision or prevention interventions. The HWD said progress notes documented Resident #11 had an unwitnessed on at approximately 11:30 a.m. Resident #11 had a to her right upper arm and to her forehead. Camera tapes showed resident hit her and was then sent to the hospital for evaluation. There was no documentation of implementation of increased supervision or prevention interventions. The HWD said on Resident #11 was found on the floor by a caregiver. The HWD said we watched the tape and it appeared she hit her Resident #11 was transported to the hospital for evaluation. The resident returned the next day. The intervention was for the family to purchase a "Merry Walker" and have instruct in its use for resident safety. The HWD said Resident #11 had an unwitnessed on at 1:28 p.m. The progress note documented the resident was last seen in her merry walker walking briskly. Resident #11 was found down on the rug with the walker on top of her. A deep gash was noted to the right forehead and an to the right side of cheek. Resident #11 was transferred to the local hospital and returned the same day. There was no documentation provided of increased supervision, interventions or education regarding resident safety and prevention. The HWD said Resident #11 had an unwitnessed on at 5:30 a.m. The resident was found on the floor inside of her walker. No injuries noted. There was no documentation of implementation of increased supervision or prevention interventions. The HWD said on at 10:55 a.m., Resident #11 was found on the floor inside	A 025		

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A 025	Continued From page 8 of her walker. Maintenance witnessed resident sideways from walker on her . Resident had an ; her was , and a lump on the forehead. Resident #11 was transferred to the hospital and diagnosed with a . There was no documentation of implementation of increased supervision or prevention interventions. The HWD said on at 8:14 a.m., Resident #11 had an unwitnessed from her merry walker. There was no documentation of implementation of increased supervision or prevention interventions. There was no post investigation tool completed. The HWD said on at 5:59 p.m., Resident #11 was found on floor in the hallway sleeping, she was unaware of . There was no documentation of implementation of increased supervision or prevention interventions. There was no post investigation tool completed. The HWD said Resident #11 had an unwitnessed on at 2:37 p. m. Resident #11 had a "deep to ". Resident #11 returned from the hospital at 6:00 p.m. with 3 staples. The HWD said progress notes documented an unwitnessed on at 1:15 p.m. Resident #11 was observed on the floor with to her . There was no documentation of implementation of increased supervision or prevention interventions. There was no post investigation tool completed. The HWD said Resident #11 progress notes documented an unwitnessed from the Merry Walker on at 11:22 a.m. Resident #11 proceeded to walk without difficulty. There was no documentation of implementation of increased supervision or prevention interventions. There was no post investigation tool completed. The HWD said Resident #11 had an unwitnessed while using	A 025		

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A 025	Continued From page 9 the Merry Walker on [illegible] at 1:00 p.m. Resident #11 had a [illegible] to her right [illegible], and a [illegible] to the bridge of her [illegible]. The HWD said the location of the [illegible] was unknown. There was no documentation of implementation of increased supervision or [illegible] prevention interventions. There was no post [illegible] investigation tool completed. The HWD said Resident #11 had an unwitnessed [illegible] on [illegible] at 9:55 a.m. Resident #11 [illegible] on her [illegible], there was [illegible] and [illegible] to the orbitals and [illegible] and the [illegible] appears to be displaced. There is also a [illegible] to the right [illegible]. The HWD said Resident #11 had an unwitnessed [illegible] on [illegible] at 1:52 p.m. after leaving the dining room. There was no apparent injury, resident #11 was assisted by 2 staff to stand and walk without difficulty. There was no documentation of implementation of increased supervision or [illegible] prevention interventions. There was no post investigation tool completed. The HWD said on [illegible] Resident #11 [illegible] at 1:20 p.m. in dining room landing on her right [illegible]. Staff noticed redness in that area. There was no documentation of implementation of increased supervision or [illegible] prevention interventions. There was no post [illegible] investigation tool completed. The HWD said progress notes documented on [illegible] at 6:43 am stated "post [illegible], resident noted with [illegible] right [illegible] and green color in right [illegible]. Will notify hospice in need of a hospital bed for easy access to care. The HWD said progress notes for Resident #11 documented on [illegible] at 1:15 p.m., " [illegible], obtained, conclusion: Displaced right [illegible] acute [illegible], sent to report to hospice and advanced practice Registered Nurse (APRN)."	A 025		

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A 025	Continued From page 10 On ... . at 10:41 a.m., The HWD said "it does not appear to me that any new or updated interventions were implemented after any of the occurred." And the service plans were not updated after any . for Resident #11. On at 12:40 p.m., Resident #11's responsible party said during a telephone interview, Resident #11 had . . and just got worse the longer she was at the facility. Resident #11 walked constantly and would scuff her . . on the carpet and . We tried a specialty apparatus (Merry Walker), but even in that it would tip over. There was almost no one around. They were not staffed to walk with her. She was capable of walking alone when she came in, but it became a problem later. The . . happened over the past year or so that she was there. On at 1:30 p.m., the Administrator said for every . we do our internal incident report, put in steps to help prevent or decrease the . and update the care plan. The "HWD should have completed the report and reviewed them with me." The administrator confirmed there are no post reports for Resident #7 and Resident #11 is no longer at the facility. Class III	A 025		
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	A 078		

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A 078	Continued From page 11 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 chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to	A 078		

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A 078	Continued From page 12 provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff . . . . . by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure for 2 (Administrator, and Staff A) of 3 staff reviewed, 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 . . . . . ( ). This has the potential to put a population at risk of developing communicable . . . . . . The findings included: Review of the Administrator's employee file on at 12:30 p.m., indicated a hire date of . . . . . The file did not contain a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable and evidence of freedom from . .	A 078		

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A 078	Continued From page 13 Review of Staff A's employee file on at 12:40 p.m., indicated a hire date of . The file did not contain a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable and evidence of freedom from . In an interview on at 1:15 p.m., the Business Manager confirmed that no documentation of freedom from communicable and evidence of freedom from was on file for the Administrator or Staff A. 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. (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	A 081		

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	AL11968916	A. BUILDING: _____ B. WING _____	12/13/2023

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A 081	Continued From page 14 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, 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	A 081		

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A 081	Continued From page 15 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 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.	A 081		

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A 081	Continued From page 16 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 2 (Director of Health and Wellness and Staff A) of 3 staff reviewed, completed required 2-hour Preservice Orientation prior to interacting with residents, and for 1 (Staff A) of 3 staff reviewed completed 3 hours of in-service training for Activities of Daily Living and Behavioral Needs; 1-hour training for Nutritional Safe Food Handling; 1-hour training for Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting; and 1-hour training for Resident Rights and Recognizing/Reporting . . . /Neglect. The findings included: Review of Director of Health and Wellness's employee record on revealed a hire date of . . . . . The record contained no documentation of completion of the 2-hour Preservice Orientation prior to interacting with residents. Review of Staff A's employee record on revealed a hire date of . . . . . The record contained no documentation of completion of 3-hour Activities of Daily Living (ADL)/Behavioral Needs training; 1-hour training for Nutritional Safe	A 081		

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A 081	Continued From page 17 Food Handling; 1-hour training for Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting; and 1-hour training for Resident Rights and Recognizing/Reporting . . . . /Neglect. On . . . . . at 1:45 p.m., the Business Manager confirmed the Health and Wellness Director and Staff A did not have the required trainings prior to providing direct/personal care to residents. Class III	A 081		
A 086 SS=D	59A-36.011(10) FAC Training - ADRD (10) . . . . . AND RELATED . . . . . ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , , and , , shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas:	A 086		

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A 086	Continued From page 18 1. Understanding . . . 's . . . . . and related ; 2. Characteristics of . . . . . ; 3. Communicating with residents with 's . . . . ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related . . . . . Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related . . . . . Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. . and Related . Level II Training must address the following subject areas as they apply to these : 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with . . . 's . . . . . and Related ," dated . . . , incorporated by reference, available from the Department of Elder	A 086		

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A 086	Continued From page 19 Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with or related , or 2. Three years of practical experience in a program providing care to persons with or related , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with or related . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of	A 086		

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A 086	Continued From page 20 this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 (Staff A) of 3 staff reviewed, completed required 4-hour in-service training for Training Level I within 3 months of hire for facilities advertising special care to residents with and related (ADRD), or who have secure areas, staff who have regular contact and/or provide direct care to residents with ADRD. This has the potential to put populations at risk. The findings included: Review of Staff A's employee record on indicated a hire date of , as a Medication Technician. The record contained no documentation of completion of the 4-hour Training Level I prior to interacting with residents. On at 1:45 p.m., the Business Manager confirmed Staff A did not have the required training prior to providing direct/personal care to residents. Class III	A 086		
AE210 SS=D	59A-36.011(8) FAC ECC - Training (8) EXTENDED CONGREGATE CARE (ECC) TRAINING.	AE210		

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AE210	Continued From page 21 (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 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 2 (Administrator and Health and Wellness Director) of 3 staff reviewed, had at least 4 hours of in-service training for Extended Congregate Care (ECC) Administrator/Supervisor, ECC concepts and requirements within 3 months of hire.	AE210		

Agency for Health Care Administration

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AE210	Continued From page 22 The findings included: 1. Review of the employee file on showed a hire date for the Health and Wellness Director of . The file did not have documentation of the required 4 hours of ECC Administrator/Supervisor training within 3 months of hire. During an interview with the Administrator on at 9:15 a.m., it was stated that the Health and Wellness Director was the designated ECC Supervisor. 2. Review of the Administrator's employee file on revealed a hire date of . The file showed the Administrator did not have documentation of the required 4 hours of ECC Administrator/Supervisor training within 3 months of hire. During an interview with the Business Manager on at 1:50 p.m., the BM confirmed that the Administrator and the Health and Wellness Director did not have documentation of the required ECC training. Class III	AE210		