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
	AL11969117	A. BUILDING: _____ B. WING _____	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARKET STREET VIERA	6845 MURRELL RD MELBOURNE, FL 32940

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CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to electronically submit to the agency, a preliminary report within 1 business day and a full report within 15 days for 1 of 6 sampled residents who sustained a with fracrure. (#1) Findings: A review of resident #1 record revealed he was admitted on . His record contained a Resident Health Assessment form (1823) dated . His diagnoses included with agitation, , , , , , and unsteady gait. He was at risk for . A review of the facility notes found: On at 8:42am resident had a unwitnessed at the side of the bed with night stand pulled to the side. No injury documented. At 2:06pm resident and shaking. , saturation 77%. Resident was sent to the hospital for generalized and was admitted for frequent and a left .	CZ821		

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CZ821	Continued From page 4 On documented at 11:03am by the DON - resident had a positive left . On at 3pm the Administrator confirmed he had not submitted a Adverse Incident Report to the agency. 	CZ821		
A 000	Initial Comments Two complaint investigations #2024013125, #2024013034, a generator monitoring, and a LNS license monitoring were conducted on and at Market Street Viera Assisted Living Facility. There were deficiencies identified at the time of the survey.	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 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	A 025		

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A 025	Continued From page 5 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 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 record reviews and interviews, the	A 025		

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A 025	Continued From page 6 facility failed to provide adequate supervision and care and services appropriate to meet the needs to ensure safety through proactive measures for 2 of 6 residents sampled. Resident #1 experienced repeated with injury. Resident #2 eloped from the secure memory care facility. Findings: 1. A review or resident #1's record revealed he was admitted on and discharged to the hospital on . His record contained a Resident Health Assessment form (1823) dated . His diagnoses included , , with agitation, , and unsteady gait. precautions were documented. A review of the facility notes found resident #1 sustained 7 : On documented at 5:01am resident was found on the floor stripped out of clothes in another resident's bathroom. No injury was documented. On documented at 7:58pm Resident found on the floor in his apartment laying on his in front of the TV. No injury documented. On documented at 5:08am Resident found laying in a supine position on the bathroom floor. Resident had complaints of , . Red marks on his right-side upper / . No other visible injuries. On documented at 3:19pm Resident was found on the floor between bed and chair. His vital signs were - saturation 83%, , , , , , . No other signs of distress. On documented at 12:08am Resident found sitting on the floor. No injuries documented	A 025		

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A 025	Continued From page 7 On documented at 1:22am Resident found laying on his next to bed. No injury noted. On documented at 8:42am Resident had an unwitnessed at the side of the bed with the nightstand pulled to the side. No injury documented. On documented at 2:06pm Resident and shaking. Resident sent to the hospital for generalized . On the Director of Nursing (DON) documented resident was admitted to the hospital for frequent . On the DON documented at 11:03am the hospital said resident had a positive left . On at 9:15am an interview with the Power of Attorney (POA) for resident #1 was conducted. She said the day resident #1 was transferred to the hospital, nurse G told her something happened in the morning. He was found on the floor. She said she arrived at 1:30pm for a regular visit and was made aware of the incident at that time. She checked her phone and did not receive a call that morning or any time that day. He had not been sent to the hospital yet. She said when they got to the hospital, he had on his and and his stuck out funny. She said the Medical Examiner (M.E.) did note as his cause of . She provided the M.E. report for review. A review of the ME report for resident #1 revealed he on . The cause of is listed as ACCIDENT. (a) PROTRACTED COMPLICATIONS OF OF MULTIPLE AND OF .	A 025		

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A 025	Continued From page 8 Other significant conditions contributing to but not resulting in the underlying cause given in part I: , Post , Protein-calorie , Date of injury Time: unknown Describe how injury occurred: Decedent . Location of injury: (Facility address) Place of injury: Assisted Living Facility On at 9:30am the incident reports were requested from the Director of Nursing (DON)for the 7 resident #1 sustained since admission to the facility to verify exact times and circumstances of incidents. She said she could not provide those reports for review. On at 10:45am an interview with unlicensed caregiver F was conducted. She said she worked from 7am to 7pm on . Resident #1 was already up at 7am when she arrived at work. The night shift got him up and dressed. Sometime just before lunch, during rounds, she said resident #1 was on the floor in the hallway. She called nurse G to evaluate him. She then assisted him to the dining room for lunch. She said he was able to answer simple questions if asked but he was unable to express himself. After lunch she noticed he was and called nurse G to check him. He was sent to the hospital. On at 11:13am an interview with nurse G was conducted via telephone. She said Resident #1 roamed around the hallways. He did not want to eat. Not eating could have made him weak. He was very difficult to redirect. She said he was found before breakfast on the floor on . He was OK and was walking around after breakfast. She said she called his wife and	A 025		

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A 025	Continued From page 9	A 025		

told her he was . When his wife arrived, he had already been sent out. She said he only had one on . In the morning. She evaluated him and he did not have any visible injuries. She also said he had a hard time expressing himself and it would have been difficult for him to verbalize , or anything. She said she was not sure what was put in place after his . He just wanted to walk.

On at 11:50am an interview with unlicensed caregiver D was conducted. She said she worked the night shift from 7pm to 7am . She did not hear that resident #1 during that shift.

On at 12:45pm an interview with the DON was conducted. She confirmed resident #1 had multiple and injuries. She said after resident #1 had and behaviors his medications were reviewed and changed. He was being seen by the psychiatrist.

The facility did not have a policy that was presented at the time of the survey. There was no documentation there was a plan of care that was written and updated after each .

2. upon arrival at the facility it was noted the road in front of the facility was 4 lanes with a median in the middle. A tour of the facility was conducted. To enter the facility the receptionist assisted in signing in and then had to use a code to open 2 locked doors to enter the residents' areas.

A review of resident #2 record revealed she was admitted on and discharged on . Her record contained an 1823 dated . Elopement risk was documented on the 1823.

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A 025	Continued From page 10 Her diagnoses included , , , , , , and history of right upper extremity . She needed supervision for bathing, , and grooming. She walked independently. A review of the facility notes found: On Saturday documented at 11:01pm - nurse A went to give resident #2 medications. The resident was not in her room. Last saw her on the other side of the building at 7:30pm. Staff were not able to locate resident #2 inside the building. Nurse A contacted the administrator. The Sheriff returned resident to the facility. They said they had contacted the resident's POA. Nurse A evaluated the resident and found no injuries. On at 12:30pm an interview with the DON was conducted. She said resident #2 was let out of the facility by a new staff member who thought she was a family member. The caregiver was working her first shift by herself, but she had been in the facility training with other staff. She said the receptionist leaves at 7pm so there was no staff at the front desk. A review of a statement written by unlicensed caregiver C on found she documented - On the evening of resident #2 came to her and asked to be let out. She had her purse and presented very well. She looked like a visitor. Unlicensed caregiver C documented she let her out. She was not aware she was a resident until she returned. A review of unlicensed caregiver C record review revealed she was hired on . On at 2:40pm an interview with the POA	A 025		

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A 025	Continued From page 11 for resident #2 was conducted. He said around 8:30pm on a deputy knocked on his door and asked if he knew resident #2. The resident had his address in her purse which she took with her when she left the facility. He said she had knocked on a stranger's door and the lady who lived there called 911. The sheriff returned her to the facility after he told the deputy at his house he would meet them there. He said he was told by the administrator she blended in with another family who was going out and the staff were unaware. On at 3:23pm in an interview with the Administrator he confirmed resident #2 eloped from the secure memory care unit. He said after resident #2 eloped they held an in-service regarding the facility elopement policy. He provided the roster. He confirmed unlicensed caregiver C was not on the roster, indicating she did not attend the in-service. He could not provide any post incident training for unlicensed caregiver C. (Photo Evidence Obtained) Class II	A 025		
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	A 030		

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A 030	Continued From page 12 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, 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	A 030		

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A 030	Continued From page 13 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 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	A 030		

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A 030	Continued From page 14 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 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	A 030		

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A 030	Continued From page 15 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 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	A 030		

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A 030	Continued From page 16 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 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	A 030		

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A 030	Continued From page 17 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 record review and interviews, the facility failed to honor a resident right to live in a safe and decent living environment free from resident to resident for 2 of 6 residents sampled. (#5, 6) Findings: A review of resident #1 record found a note documented on reported that resident went into resident #5's room and hit her in the . Resident confirmed she was hit in the which may have been a closed fist. A review of resident #5's record revealed she was admitted on . Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included 's, lower extremity , , , and She was under Hospice care. A review of the facility notes found a note dated documented by nurse K at 5:30am. The nurse was summoned to find resident sitting in	A 030		

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A 030	Continued From page 18 the hall near her room. Resident #5 reported resident #1 walked into her room and hit her in the . Red pinpoints observed on her left cheek. Resident #5 complained of , . ´ were ordered. Negative results received on . A review of resident #1 record revealed a facility note documented on by nurse H at 4:34am- resident#1 slapped resident #6 "behind the ". 2. A review of resident #6 record revealed she was admitted on . Her record contained an 1823 dated . Her diagnoses included ' ' ,, , , and ,' . Further review of her record did not find documentation of her being slapped by resident #1 on as documented in resident #1's facility notes. The DON said in an interview on at 1:30pm she was unaware of the incident and reached out to nurse H. Nurse H provided a statement to the DON on in which he said it was not a slap but just touching her on her . He attributed the mistake to a language barrier. She confirmed resident #6's family was not notified of the event. She was unable to provide an incident report to confirm dates and circumstances of the incident. At the time of the survey the facility had not investigated and did not put any interventions in place. (Photo Evidence Obtained)	A 030		

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A 030	Continued From page 19 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 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	A 032		

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A 032	Continued From page 20 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. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide documentation for currently employed facility direct care staff for training in the facility's policies and procedures regarding elopement standards for 1 of 6 staff sampled. (B) Findings: A review of unlicensed caregiver B's record revealed she was hired on . Her elopement online training certificate dated did not document the time or date she	A 032		

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A 032	Continued From page 21 received training on the facility specific elopement policy. Class III	A 032		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) 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. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice	A 081		

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A 081	Continued From page 22 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, including universal precautions and facility sanitation procedures, before providing personal	A 081		

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A 081	Continued From page 23 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 within 30 days of employment in safe food handling practices.	A 081		

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A 081	Continued From page 24 (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 all employees had a statement signed by the Administrator and the employee documenting the employee completed the required preservice orientation for 1 of 6 employees sampled. (A) Findings: Review of nurse A's record revealed she was hired on and terminated on . Her record contained a certificate for preservice orientation dated . It was not signed by the employee. Class III	A 081		
A 090 SS=D	59A-36.011(11) FAC Training - (11)	A 090		

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A 090	Continued From page 25 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 provide documentation for currently employed direct care staff of at least one hour of training in the facility's policies and procedures regarding ( ) for 1 of 6 staff reviewed. Findings: A review of unlicensed caregiver B's record revealed she was hired on . Her online training certificate dated did not document the time or date she received training on the facility specific policy. Class III	A 090		