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
	AL11967587	A. BUILDING: _____ B. WING _____	C 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENNITY AT MELBOURNE (THE)	7365 ORCHESTRA LN MELBOURNE, FL 32940

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ZZ000	Initial Comments 2024015863	ZZ000		
CZ813	59A-35.090(3)(c), FAC Results of Screening & Notification In File 59A-35.090 Background Screening. (3) Results of Screening and Notification. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide an Attestation of Compliance with Background Screening for 1 of 5 staff reviewed D. Findings: On the record for the LNS nurse D was requested. The Administrator said the record could not be provided because she was a nurse hired on . At 3pm the Administrator confirmed they could not provide an Attestation of Compliance with Background Screening. Unclassified	CZ813		
CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any	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 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. 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	CZ821		

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CZ821	Continued From page 2 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 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be	CZ821		

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CZ821	Continued From page 3 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 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.	CZ821		

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CZ821	Continued From page 4 (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 review and interview the facility failed to submit an adverse incident report electronically to the Agency within 1 business day after an elopement from the secure memory care unit for 1 of 4 residents sampled. (#3) Findings: A review of resident #3's record revealed he was admitted on . He lived in the secured memory care unit. His record contained a Resident Health Assessment (1823) dated . His diagnoses included , , cardia, , , , and . A review of the facility notes revealed on Sunday documented at 8:02am by nurse H - writer was informed that resident was observed in his room sitting on the side of the bed complaining of , and unable to stand up. The resident reported he thinks he . Sent to the hospital for evaluation and treatment. Diagnosed with a small acute hematoma and a left . On at 3:25pm the Adverse Incident Report was requested from the administrator. She confirmed she had not submitted a day 1	CZ821		

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CZ821	Continued From page 5 report to the agency. Unclassified.	CZ821		
A 000	Initial Comments A survey for complaint #2024015863 and a Limited Nursing Services licensure monitoring were conducted on at Brennity at Melbourne Assisted Living Facility. There were deficiencies identified at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or	A 010		

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A 010	Continued From page 6 a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the	A 010		

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A 010	Continued From page 7 resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a may be retained provided that:	A 010		

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A 010	Continued From page 8 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any	A 010		

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A 010	Continued From page 9 nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update the Resident Health Assessment to ensure the appropriateness of continued residency of resident #2, an individual who was at risk of elopement. Findings: A review of resident #2's record revealed she was admitted on . She lived in the secure memory care unit. Her record contained a Resident Health Assessment form (1823) dated . The 1823 documented resident was not an elopement risk. A review of a facility note documented on at 1:38pm by Nurse (l) -Author notified by memory care director that resident was observed outside of the memory care courtyard on the exterior side of the exit gate. On at 10:40am the Administrator confirmed resident #2 eloped from the secure memory care unit. The lawn care company propped the courtyard gate open which allowed resident #2 an exit. Class III	A 010		

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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 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	A 025		

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A 025	Continued From page 11 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 reviews, and interviews, the facility failed to provide adequate supervision and care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for and injuries for 3 of 4 sampled residents (1, 3, 4) who experienced repeated with injuries and resident #2 who eloped from the secure memory care unit. Findings: A review of resident #1's closed record revealed she was admitted on and on . She lived in the secure memory care unit. Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses included , , and low , . She used a walker or a wheelchair. She was oriented to self, she required	A 025		

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A 025	Continued From page 12 precautions, and she was under Hospice care. She required assistance with all activities of daily living (ADL). A facility note dated 11/24/24 documented at 7:12pm by nurse (I) - Author notified that resident was observed laying on the floor in another resident's room asking for help. Transfer to the hospital for an evaluation. A facility note dated 11/24/24 documented at 9:45pm by nurse (I) - Author notified resident returned to the community. A review of the hospital record dated 11/24/24 found resident arrived at 7:26pm due to a with uncertain cause. Laboratory tests included a CT of with no findings. A facility note dated 11/24/24 at 11:13pm documented by nurse (J) - report of resident having a . The resident hit her on the floor. Noted moderate from the forehead area. Transfer to the hospital for further medical attention. A review of the hospital records dated 11/24/24 found resident arrived at 11:14pm. A CT of the found an intraparenchymal 8.3x4.5x4.7cm with surrounding , effect, and shift approximately 6cm. There was a 1.5 cm to her forehead. She expired on at 3:22am while awaiting transfer to the hospice in patient unit. 2. A review of resident #3 record revealed he was admitted on . He lived in the secure memory care unit. His record contained 1823 dated . His	A 025		

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A 025	Continued From page 13 Diagnoses included , , cardia, , , , , and . He was oriented to self and under Hospice care. He required supervision for ambulation, eating, and transfer and assistance with all other ADL's. A facility note documented on at 12:54pm by nurse (K) - Alerted resident was assisted off floor after bathing. The hospice aid stated she put him on the floor, he did not . A facility note documented on at 10:42am by nurse (L) - alerted that resident had witnessed a in the hallway. A facility note documented on 11/5/24 at 5:04pm by nurse (H) - This writer was notified that resident had an unwitnessed coming in from the courtyard. A resident was observed laying on his . A facility note documented on at 8:02am by nurse H - writer was informed that resident was in his room observed sitting on the side of the bed complaining of , and unable to stand up. The resident reported he thinks he . Sent to the hospital. A review of the hospital records dated found resident arrived at 7:45am complaining of left , , , , and , . He was unable to stand. He was admitted with a diagnosis of a Small acute sub dural hematoma and left , . 3. A review of resident #4's record revealed she was admitted . She lived in the secure memory care unit.	A 025		

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	AL11967587	A. BUILDING: _____ B. WING _____	C 12/11/2024

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A 025	Continued From page 14 Her record contained an 1823 dated . Her diagnoses included -fib, , , , and , . She was under hospice care. She was unsteady at times. Oriented to self. She required supervision with ambulation, eating, and transfer and assistance with all other ADL's. A review of the facility notes found 11 documented. A facility note documented on at 4:24pm by nurse (H) - Resident had an unwitnessed in an unoccupied room. A facility note documented on at 5:58pm by nurse (K) - Author alerted to resident being on the ground. Staff witnessed resident throwing herself on the ground. to right . A facility note documented on at 10:44pm by nurse (J) - Reported resident had a earlier in the day prior to evening shift. Notes discoloration to forehead. A facility note documented on at 11:22am by nurse (L) - Unwitnessed reported at 1:30am. Resident was observed lying on the floor next to her bed. Stated she hit her . Sent to hospital for eval. A facility note documented on at 7:30am by nurse (L) - resident was observed sitting on the floor in her room. A facility note documented on at 1:31pm by nurse (L) - Resident was observed sitting on the floor in an empty room this morning. A facility note documented on at 8:39am by nurse (H) - the writer was notified this morning resident went out to the hospital for an unwitnessed . Resident was in the community when arrived to work. A facility note documented on 11/1/24 at 9:42am by nurse (H) - resident was observed sitting on	A 025		

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A 025	Continued From page 15 the floor. A facility note documented on 11/2/24 at 10:48pm by Nurse (M) - Found resident on the floor in her room. to upper left arm. A facility note documented on 11/3/24 at 6:41am by nurse (N) - Resident observed lying on the floor. A facility note documented on 11/4/24 at 11:24am by nurse (L) - report that resident was observed lying on the floor in her room. On at 3:30pm the administrator confirmed resident #1 had 2 within 4 hours resulting in a significant injury, resident #3 sustained 4 with injury, and resident #4 sustained multiple (11) with injury. This surveyor requested a service plan and/or documentation of mitigating strategies that were put in place for risk residents. The administrator was unable to provide any documentation of mitigating strategies. A review of the facility policy revealed a was defined as unintentionally coming to rest on the ground, floor, or lower level either witnessed or unwitnessed, with or without injury. . 4. On at 11:20am resident #2 was observed during rounds in the memory care dining room. She was wearing an identification bracelet on her left . A review of resident #2's record revealed she was admitted on . She lived in the secure memory care unit. Her record contained an 1823 dated . Her diagnoses included -fib and . Her 1823 did not indicate resident was at risk for elopement. She was independent ambulation. She required	A 025		

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A 025	Continued From page 16 supervision with eating, toilet, and transfer and Assistance with other grooming and bathing. She was under Hospice care. Review of a facility note dated at 1:38pm by nurse (I) - Author notified by memory care director (MCD) that resident #2 was observed outside of the memory care courtyard on the exterior side of the exit gate. On at 11:30am interview with MCD (D). She confirmed resident #2 was able to elope from the secure memory care unit on because the lawn company propped the gate open with a rock. She said the lifestyles assistant noticed the gate was open and went to check it. She found resident #2 outside the gate and brought her inside. A walk was conducted with the MCD to the courtyard. We exited through a door next to the dining room which led to a screened patio. We exited the patio door onto a courtyard sidewalk. The iron gate used by resident #2 was to the right of the patio. The door was locked at the time of the tour. The gate led to a sloped sidewalk which led directly to the neighborhood street. There was no sidewalk parallel to the street. On at 3:15pm an interview with the administrator was conducted. She confirmed resident #2 eloped from the secured memory care unit. She said the lawn care company propped the gate open when they were working in the courtyard. When asked how the lawn care company gained access to the secure unit, she answered they had the code to open the gate. She said they no longer have the code. A review of the facility elopement policy revealed	A 025		

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A 025	Continued From page 17 elopement was defined as an incident in which a resident leaves the community without community associates' knowledge: unsupervised, unscheduled and unnoticed. This applies especially when the resident has , decision-making abilities and is unaware of his/her own safety needs. This includes residents that leave a secure area without associates' knowledge. Class II	A 025		
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	A 032		

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A 032	Continued From page 18 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. (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:	A 032		

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A 032	Continued From page 19 Based on record review and interview the facility failed to provide documentation for currently employed facility direct care staff of training in the facility's policies and procedures regarding elopement standards for 3 of 5 staff sampled. (A, B, C) Findings: A review of unlicensed caregiver A's record revealed she was hired on . Her elopement online training did not document the time or date she received training on the facility specific elopement policy. A review of unlicensed caregiver B's record revealed she was hired on . Her elopement online training did not document the time or date she received training on the facility specific elopement policy. A review of unlicensed caregiver C's record revealed he was hired on . His elopement online training did not document the time or date he received training on the facility specific elopement policy. Class III	A 032		
AN277 SS=D	59A-36.022(2) FAC LNS - Resident Care Standards (2) RESIDENT CARE STANDARDS. (a) A resident receiving limited nursing services in a facility holding only a standard and limited nursing services license must meet the admission and continued residency criteria specified in Rule 59A-36.006, F.A.C.	AN277		

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AN277	Continued From page 20 (b) In accordance with Rule 59A-36.010, F.A.C., the facility must employ sufficient and qualified staff to meet the needs of residents requiring limited nursing services based on the number of such residents and the type of nursing service to be provided. (c) Limited nursing services may only be provided as authorized by a health care practitioner's order, a copy of which must be maintained in the resident's file. (d) Facilities licensed to provide limited nursing services must employ or contract with a nurse(s) who must be available to provide such services as needed by residents. The facility's employed or nurse must coordinate with third party nursing services providers to ensure resident care is provided in a safe and consistent manner. The facility must maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files. (e) The facility must ensure that nursing services are conducted and supervised in accordance with Chapter 464, F.S., and the prevailing standard of practice in the nursing community. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of the qualifications of nurses providing limited nursing services in the facility's personnel files for 1 of 5 staff sampled. (D) Findings: On at 12:20 pm requested the LNS nurse's record. The Administrator comfirmed she could not provide a record because she was a nurse hired on .	AN277		

Agency for Health Care Administration

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AN277	Continued From page 21 Class III	AN277		