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
	AL11970223	A. BUILDING: _____ B. WING _____	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
81 OAKS SENIOR LIVING	8000 HAWKINS RD SARASOTA, FL 34241

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A 000	Initial Comments An announced relicensure, limited nursing services, emergency power plan monitoring, health facility reporting systems, visitation form and complaint investigation for #2025010663 was conducted at 81 Oaks Senior Living on through . Deficiencies were identified at the time of survey.	A 000		
A 009 SS=D	59A-36.006(3) FAC; 400.0078(2) Admissions - Admission Package (3) ADMISSION PACKAGE. (a) The facility must make available to potential residents a written statement(s) that includes the following information listed below. Providing a copy of the facility resident contract or facility brochure containing all the required information meets this requirement. 1. The facility's admission and continued residency criteria; 2. The daily, weekly or monthly charge to reside in the facility and the services, supplies, and accommodations provided by the facility for that rate; 3. Personal care services that the facility is prepared to provide to residents and additional costs to the resident, if any; 4. Nursing services that the facility is prepared to provide to residents and additional costs to the resident, if any; 5. Food service and the ability of the facility to accommodate special diets; 6. The availability of transportation and additional costs to the resident, if any; 7. Any other special services that are provided by the facility and additional cost if any;	A 009		

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A 009	Continued From page 1 8. Social and leisure activities generally offered by the facility; 9. Any services that the facility does not provide but will arrange for the resident and additional cost, if any; 10. The facility rules and regulations that residents must follow as described in Rule 59A-36.007, F.A.C.; 11. The facility policy concerning pursuant to Section 429.255, F.S., and Rule 59A-36.009, F.A.C., and Advance Directives pursuant to Chapter 765, F.S.; 12. If the facility is licensed to provide extended congregate care, the facility's residency criteria for residents receiving extended congregate care services. The facility must also provide a description of the additional personal, supportive, and nursing services provided by the facility including additional costs and any limitations on where extended congregate care residents may reside based on the policies and procedures described in Rule 59A-36.021, F.A.C.; 13. If the facility advertises that it provides special care for individuals with and related , a written description of those special services as required in Section 429.177, F.S.; and, 14. The facility's resident elopement response policies and procedures. (b) Before or at the time of admission, the resident, or the resident's responsible party, guardian, or attorney-in-fact, if applicable, must be provided with the following: 1. A copy of the resident's contract that meets the requirements of Rule 59A-36.018, F.A.C., 2. A copy of the facility statement described in paragraph (a) of this subsection, if one has not already been provided, 3. A copy of the resident's bill of rights as required	A 009		

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A 009	Continued From page 2 by Rule 59A-36.007, F.A.C.; and, 4. A Long-Term Care Ombudsman Program brochure that includes the telephone number and address of the district office. (c) Documents required by this subsection must be in English. If the resident is not able to read, or does not understand English and translated documents are not available, the facility must explain its policies to a family member or friend of the resident or another individual who can communicate the information to the resident. 400.0078 (2) Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding: (a) The purpose of the State Long-Term Care Ombudsman Program. (b) The statewide toll-free telephone number and e-mail address for receiving complaints. (c) Information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. (d) Other relevant information regarding how to contact representatives of the State Long-Term Care Ombudsman Program. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure resident agreements/contracts contained all requirements per 59A-36.018 (1)(a) FAC., for 4 (Resident # 20,21,22, 26) of 4 resident contracts reviewed. The facility failed to abide by the Federal Fair Housing Act, which prohibits housing providers from refusing residency to persons with , or placing conditions on their residency, because those persons may require reasonable	A 009		

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A 009	Continued From page 3 accommodations. The findings included: Record review of Resident #20's Assisted Living and Memory Care Resident Agreement signed by the Resident's sponsor, revealed the Agreement did not contain a list of specific services to be provided by the facility for limited nursing services that the resident elected to receive, including associated costs if any. Record review of the facility's Limited Nursing Services (LNS) Binder showed Resident #20 was receiving LNS services starting for brace assist due to , daily and prn (as needed). There is no date documented to indicate when/if LNS services were discontinued. Record review of Resident #21's Assisted Living and Memory Care Resident Agreement signed by the Resident's sponsor, revealed the Agreement did not contain a list of specific services to be provided by the facility for limited nursing services that the resident elected to receive, including associated costs if any. Record review of the facility's LNS Binder showed Resident #21 was receiving LNS services starting for care due to , and , retention daily and prn. There is no date documented to indicate when/if LNS services were discontinued. Record review of Resident #22's Assisted Living and Memory Care Resident Agreement signed by the Resident, the Agreement did not contain a list of specific services to be provided by the facility for limited nursing services that the resident elected to receive, including associated costs if	A 009		

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A 009	Continued From page 4 any. Record review of the facility's LNS log showed Resident #22 was provided LNS for " , Care" daily and prn starting with no date services were discontinued listed in the log. On during a record review of Resident #26's Assisted Living and Memory Care Resident Agreement, the Agreement was never signed by the Sponsor. The signature line on the document contained only initials. There was no full signature contained on the document. Record review of the Resident Agreement, Exhibit D-2, indicated the following:: "residents with motorized carts shall pay a $500.00 annual maintenance fee regardless of any damage incurred, along with proof of a physicians order that the motorized cart is a necessary accommodation." On , at 1:01 p.m., during an interview, the Executive Director (ED) said they charge residents with electric scooters $1000 as a one-time fee, and the residents with electric scooters is less than 10. The ED said the $1000 is for damages because we have to replace the carpet or the drywall, now we are doing walk through's. When they move out we have had to remove the carpet like if people had pets. The ED said the carpet is $700 to replace in the the largest bedroom, the drywall is different. The ED said that the list is not in the contract yet. On at 1:05 p.m., during an interview, the ED said that the contract had a lot of work that had to be done to fix it. The ED said that the fact that the LNS was not in the contract was one thing that had to be fixed and acknowledged that	A 009		

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A 009	Continued From page 5 the $1000 fee for motorized carts with a physicians order was against the Federal Fair Housing Act. Class III .	A 009		
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 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,	A 010		

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A 010	Continued From page 6	A 010		

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 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

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A 010	Continued From page 7 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: 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	A 010		

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A 010	Continued From page 8 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 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	A 010		

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A 010	Continued From page 9 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 have a plan of care for the resident that delineated how the facility and the hospice specified which services were to be provided by hospice and which services were to be provided by the facility for 1 (Resident #24) out of 3 Residents on Hospice reviewed. The facility also failed to ensure that a resident had an updated Resident Health Assessment Form 1823 after a significant change for 2 (Resident #25 and #24) out of 3 Residents on Hospice reviewed. The findings included: 1. On , record review of the Hospice and Facility Coordinated Plan of Care for Resident #24 dated , showed the Hospice Nurse would identify level of care and coordinate any change in level of care with Hospice Interdisciplinary group and facility nurse. It did not specify in the plan which services the Assisted Living Facility would provide and which services the Hospice would provide, only frequency of visits. On at 10:45 a.m., during an interview, the Wellness Director agreed that the Hospice Coordinated Plan of Care does not show which services the Hospice will do and which the facility does. 2. On , record review of Resident #24's medical record showed an order for Hospice referral dated . The Health Assessment Form 1823 was signed on by a Nurse Practitioner.	A 010		

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A 010	Continued From page 10 On during a record review of Resident #25's medical record, it showed an order for Hospice referral dated . The Health Assessment Form 1823 was signed on by a Doctor of , . On at 4:00 p.m., during an interview, the Wellness Director agreed the Health Assessment Form 1823s should have been updated when each Resident was referred to Hospice. Class III .	A 010		
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 11 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 review, and interview, the facility failed to be aware of the physical well-being of residents and failed to maintain a written record of any significant change in 1 (Resident #25) out of 2 records reviewed.	A 025		

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A 025	Continued From page 12 The findings included: On , record review revealed the Hospice Outside Agency Documentation Form for Resident #25 dated , documented " has , injury to measuring 2.5 x 1.5 cm x <0.1 cm." The Hospice Outside Agency Documentation form for Resident #25 dated did not mention the , or if care was done. On , record review of the Facility's Nurse's Notes dated and did not note a , or any services provided for the . On at 4:00 p.m., during an interview, Licensed Practical Nurse Staff L said she did not know when the , started and that Hospice takes care of it. On at 4:00 p.m., during an interview, the Wellness Director said she had not seen the . Class III .	A 025		
A 052 SS=E	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph,	A 052		

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A 052	Continued From page 13 an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or	A 052		

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A 052	Continued From page 14 crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a , of the body. (d) Administration of , preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with	A 052		

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A 052	Continued From page 15	A 052		

self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule.
(b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,

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A 052	Continued From page 16 or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff assisting with self administration of medications do so appropriately and perform hygiene according to facility policy for 5 (Resident #13, #14, #15, #16, #17) of 5 residents observed for medication pass. The findings included: Facility Policy: IC03 - Hygiene. Policy Date: Policy : hygiene is a critical step in control. Care Staff will follow proper hygiene procedures. hygiene can be completed through proper handwashing and/or use of based sanitizer. hygiene will be used to aid in the prevention and spread/transmission of . . . .Procedure: 5. Care staff must always wash their when assisting residents including: . . . e. Before and after assisting with medications.	A 052		

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A 052	Continued From page 17 On at 12:10 p.m., during observation of the medication pass, Medication Technician (MT) Staff B provided 60 mg (medication) to Resident #13. MT Staff B failed to perform hygiene after the medication pass. On at 12:12 p.m., during observation of the medication pass, MT Staff B provided 20 mg ( ) to Resident #14. MT Staff B failed to perform hygiene before and after the medication pass. On at 12:17 p.m., during observation of the medication pass, MT Staff B provided 25 mg ( ) to Resident #15. MT Staff B failed to perform hygiene before and after the medication pass. On at 12:25 p.m., during observation of the medication pass, MT Staff B provided 5 mg. MT Staff B crushed the medication and mixed the medication in a cup of applesauce. MT Staff B placed the spoon containing the medication and the applesauce directly into the of Resident #16. MT Staff B failed to perform hygiene before and after the medication pass. On at 12:30 p.m., during observation of the medication pass, MT Staff B provided 20 mg ( ) to Resident #17. MT Staff B failed to perform hygiene before and after the medication pass. On at 1:47 p.m., during an interview, MT Staff B acknowledged she did not sanitized her after each medication pass and that she has sanitizer on her cart and on her person. MT Staff B acknowledged that this was against	A 052		

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A 052	Continued From page 18 regulation. On at 1:50 p.m., during an interview, MT Staff B said Resident #16 will sometimes take the spoon and self-administer medications but other times she won't. Staff B said Resident #16 was in , and after she directly fed the medications to Resident #16, she realized that she had done something against regulation. On at 3:15 p.m., during an interview, the Director of Memory Care said the department policy on hygiene during assistance with self-administration of medications is to wash your at the beginning of the pass and then some sort of sanitization in between each resident. The MCD acknowledged the lack of compliance from the MT during the med pass for handwashing and said that some retraining needs to happen. The Memory Care Director said the unlicensed Medication Technician shouldn't have directly administered medications and that they are trained to provide over support that is complaint with regulations. The Director confirmed that placing a spoon directly into the of the resident is against regulations for the med tech. Class III .	A 052		
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	A 081		

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A 081	Continued From page 19	A 081		

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 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

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A 081	Continued From page 20 (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 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	A 081		

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A 081	Continued From page 21 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. 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.	A 081		

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A 081	Continued From page 22	A 081		

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure all direct care employees completed 1 hour of Control training based on facility policies and procedures for 3 (Staff A, C, D). The facility failed to ensure staff completed Elopement Response training based on facility-based policies and procedures for 4 (Staff A, C, D, Executive Director) of 4 records reviewed.

The findings included:

On , record review of employee files revealed that Caregiver Staff A had a hire date of . 2 hours of Control training completed on and 2 hours of Elopement training was documented through Allen Flores Academy, an online computer-based training system. Caregiver Staff A failed to complete the required facility-based training.

Record review of employee files revealed Caregiver Staff C had a hire date of .Staff C's file contained documentation of 3 hours of Control training completed on , and 0.5 hours of Elopement training completed through Relias, an online computer-based training system. Caregiver Staff C failed to complete the required training based on facility policy and procedures.

Record review of employee files revealed Caregiver Staff D had a hire date of . Staff D's file contained documentation of Control training completed on through

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A 081	Continued From page 23 Allen Flores Academy, an online computer-based training system. There was no evidence of completion of Elopement training documented in Staff D's file. Caregiver Staff D failed to complete the required training. Record review of employee files revealed the Executive Director (ED) had a hire date of . The ED's file contained documentation of 1 hour of elopement training on through Allen Flores Academy, an online computer-based training system. The ED failed to complete the required training based on the facility policy and procedures. On at 10:20 a.m., during an interview, the Executive Director (ED) said that there is currently no business manager, and the entire team is working on staff records. The ED said the staff that has been there for a while has done only Relias training, and she is aware that some of the trainings need to be facility specific and not generalized and acknowledged the facility failed to provide the necessary documentation. Class III	A 081		
A 082 SS=D	59A-36.011(4) FAC Training - / (4) / (/). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on	A 082		

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A 082	Continued From page 24 and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. 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 4 staff records reviewed contained documentation of completion of the required / training. The findings included: Record review of employee files revealed Caregiver Staff A had a hire date of . Staff A's employee file contained no documentation of having completed the required / training. On at 10:20 a.m., during an interview, the Executive Director (ED) said there is currently no business manager, and the entire team is working on staff records. The ED acknowledged that there are issues with the training process. Class III .	A 082		
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	A 078		

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A 078	Continued From page 25 of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training	A 078		

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A 078	Continued From page 26 requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for 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 staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable within 30 days of employment, for 4 (Staff A, C, D and Executive Director) of 4 records reviewed. The findings included: Rrecord review of employee files revealed Caregiver Staff A had a hire date of . Staff A's employee file contained no documentation of a written staetment of freedom of signs/symptoms of communicable signed by the healthcare provider.	A 078		

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A 078	Continued From page 27 Record review of employee files revealed Caregiver Staff D had a hire date of . Staff D's employee file contained no documentation of written staetment of freedom of signs/symptoms of communicable signed by the healthcare Record review of employee files revealed Caregiver Staff C had a hire date of . Staff C's employee file contained no documentation of written staetment of freedom of signs/symptoms of communicable signed by the healthcare provider.. Record review of employee files revealed the Executive Director (ED) had a hire date of . The ED's employee file contained no documentation of written staetment of freedom of signs/symptoms of communicable signed by the healthcare provider.. On at 10:20 a.m., during an interview, the Executive Director (ED) said that there is currently no business manager, and the entire team is working on staff records. The ED said she was unaware that a communicable statement is required and was a regulation. The ED acknowledgedt none of the employee files had such a statement in them. Class III .	A 078		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and	A 083		

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A 083	Continued From page 28 holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure there was at least one staff person on each shift with valid ( ) and First Aid certifications. The findings included: Review of the facility Clinical Policy and Procedure Manual - Florida (3) - 59A - 36.010, "A staff member who has completed courses in First Aid and ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the	A 083		

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A 083	Continued From page 29	A 083		

course requirement for First Aid. An emergency medical technician or paramedic currently certified under Chapter 401, Part III, F.S., is considered as having met the course requirements for both First Aid and .

Review of the staff schedule for the month of , revealed the following days and shifts did not meet the requirement:

On from 10:00 p.m. to 6:00 a.m., Staff I was certified for but was not certified for First Aid.

On from 10:00 p.m. to 6:00 a.m., there were no staff scheduled in the facility who were certified for and First Aid.

On from 2:00 p.m. to 10:00 p.m., Staff I and F were certified for but were not certified for First Aid; from 10:00 p.m. to 6:00 a.m., Staff G was certified for butwas not First Aid certified.

On from 10:00 p.m. to 6:00 a.m., Staff C was certified for but was not certified for First Aid.

On from 10:00 p.m. to 6:00 a.m., Staff G was certified for but was not certified for First Aid.

On at 3:35 p.m., during an interview, the Executive Director (ED) said she did not have and First Aid certifications for all of the staff working in the facility. The ED acknowledged there were several shifts that did not meet the requirement for and First Aid certified staff on duty. The ED said she provided the certificates

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A 083	Continued From page 30 she had and was aware some were expired. Class III .	A 083		
A 090 SS=D	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure all direct care employees completed 1 hour of ( ) training for 4 (Executive Director, Staff A, Staff C, Staff D) of 4 records reviewed. The findings included: On , record review of employee files revealed that Caregiver Staff A had a hire date of . Staff A's employee file contained no documentation of having completed 1-hour training in .	A 090		

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A 090	Continued From page 31 On , record review of employee files revealed that Caregiver Staff C had a hire date of . Staff C's employee file contained no documentation of having completed 1-hour training in . On , record review of employee files revealed that Caregiver Staff D had a hire date of . Staff D's employee file contained no documentation of having completed 1-hour training in . On , record review of employee files revealed that the Executive Director (ED) had a hire date of . The ED's employee file contained no documentation of having completed 1-hour training in . On at 10:20 a.m., during an interview, the Executive Director (ED) said that there is currently no business manager, and the entire team is working on staff records. The ED said that the staff that has been there for a while has done only Relias training. She is aware that some of the trainings need to be facility specific and not generalized and acknowledged the facility failed to provide the necessary documentation. Class III .	A 090		
A 093 SS=H	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS.	A 093		

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A 093	Continued From page 32 (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among	A 093		

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A 093	Continued From page 33	A 093		

three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.
2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.
(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For

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A 093	Continued From page 34 residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of _ the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure staff provide therapeutic diets as ordered by a physician for 2 (Resident #11, #12) of 2 residents. The facility failed to provide meals through the use of standardized recipes. The findings included: Record review on of the Agency for Healthcare Administration (AHCA) Resident Health Assessment Form 1823 for Resident #11 showed an order from a healthcare provider dated indicating Resident #11 required a Mechanical Soft Diet.	A 093		

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A 093	Continued From page 35 Record review on of the Agency for Healthcare Administration (AHCA) Resident Health Assessment Form 1823 for Resident #12 showed an order from a healthcare provider dated indicating Resident #12 required a ground diet. On , at 11:30 am, during observation of lunch service, Resident #12 was observed sitting in the dining room. At 11:35 p.m., Resident #12 was served lunch and began eating. At 11:40 a.m., after beginning to eat, Resident #12 began to choke. Medication Technician Staff B was able to get behind her and dislodge the piece of food caught in her . Resident #12 spit up her meal and was taken away to be cleaned up. Upon further observation, Resident #12's meal was cut into large pieces and not ground as per physician diet orders. On at 11:55 a.m., the Memory Care Director was notified of the incident, entered the dining room, and saw the plate of food. The Memory Care Director observed the texture of the food and acknowledged the food provided to Resident #12 was not ground as per the physician diet order. On , at 12:00 p.m., during observation of lunch service, Resident #11 was seen eating lunch. Upon further observation, Resident #11's meal contained full-sized, fresh cooked broccoli florets. Full size broccoli florets are not suitable for a mechanical soft diet Record review of facility records revealed the menu being utilized is a 4-week cycle menu.	A 093		

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A 093	Continued From page 36 There were no recipes attached to any of the menu items and the menu had not been approved by a dietician. There were no recipes for therapeutic or modified diets documented. On , at 12:22 p.m. during an interview, the Director of Dining Services (DDS) said the breakfast cook is responsible for diet texture modifications, and himself and his assistant are responsible for lunch and dinner. The Director of Dining Services said mechanical soft and ground diets are prepared the same and are one in the same. The DDS said the current menu is a 4 week cycle menu that is simply a list of items that are to be served for each meal period. The Director of Dining Services said there are no recipes or extensions attached to any of the menu items; he and his team are flying and creating food based on their ideas that day, and there are no instructions for diet modifications. On , at 1:02 p.m. during an interview with the Executive Director (ED) and the Director of Dining Services. The Director of Dining Services admitted that he had made a mistake and sent out a mechanical soft meal instead of a ground order for Resident #12. The ED acknowledged his mistake. The ED said that training needs to be done and agreed to have a dietician onsite to provide the necessary training to be sure that alternate diets and textures are being followed. The Director of Dining Services said that when the menu is posted, each cook is making their own decisions on how to execute the menu, picking their own ingredients and quantities. On , at 3:15 p.m., during an interview, the Director of Memory Care (DMC)said Resident #12 had choked before and that initiated the diet change to a ground diet. The DMC said that there	A 093		

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A 093	Continued From page 37 have been times when she has had to return food to the kitchen because it wasn't modified for texture correctly. On , at 3:25 p.m., during an interview, Caregiver Staff E said that she had not been trained in diet modifications by the facility and was not sure about the differences in texture of foods. On , at 3:35 p.m., during an interview, Caregiver Staff F said that she did not think that there were any residents on a ground diet. ** Photographic Evidence Obtained ** Class II .	A 093		
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. (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	AN277		

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AN277	Continued From page 38 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 interviews, the facility failed to obtain a health care practitioner's order for Limited Nursing Services (LNS) and maintain a copy in the resident's file in 2 (Residents #20 and #21) of 3 residents reviewed that received LNS services. The findings included: On , record review revealed "Policy GP16 - Limited Nursing Services, Policy Date: . . . Procedure: 5. Limited nursing services may only be provided as authorized by a health care provider's order, a copy of which must be maintained in the resident's file." 1. On , during a record review of the facility's LNS Binder showed Resident #20 was receiving LNS services starting for brace assist due to , daily and prn (as needed). There is no date LNS services were discontinued. On during a record review of the medical record of Resident #20, no order for applying or	AN277		

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AN277	Continued From page 39 removing a brace was found. On at 4:30 p.m., during an interview, the Wellness Director said she could not find an order for a brace in Resident #20's records. 2. On during a record review of the facility's LNS Binder showed Resident #21 was receiving LNS services starting for care due to and retention daily and prn. There is no date LNS services were discontinued. On during a review of the medical record of Resident #21, no order for care was found. On at 4:30 p.m., during an interview, the Wellness Director said she could not find an order for care in Resident #21's records. Class III	AN277		
AN278 SS=D	59A-36.022(3) FAC; 429.07(3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained for each resident who receives limited nursing services from facility staff. (c) A nursing assessment conducted at least monthly must be maintained on each resident	AN278		

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AN278	Continued From page 40 who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health... This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to keep accurate records for 3 (Residents #20, #21, and #22) of 3 residents reviewed that had received limited nursing services. The facility failed to ensure and maintain documentation that a nursing assessment was completed by a Registered Nurse at least monthly per 59A-36.002 (28) F.A.C. The facility failed to ensure and maintain nursing progress notes completed by a nurse describing the services rendered at the time of service per 59A-36.002 (29) F.A.C. The findings included: On , record review revealed "Policy GP16-Limited Nursing Services Policy Date: , . . . Procedure: . . . 8 b. Nursing progress notes must be maintained for each resident who receives limited nursing services. i. The progress notes must be completed by the nurse who delivered the service; must describe the date, type, scope, amount, duration, and outcome of services that are rendered; must describe the general status of the resident's health; must describe any contact with the resident's physician; and must contain the signature and credential initials of the person	AN278		

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AN278	Continued From page 41 rendering the service. . . c. A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. i. The assessment must contain the signature and credential initials of the person who conducted the assessment." 1. On during a record review of the facility's LNS log showed Resident #20 was receiving LNS beginning on for brace assist due to , daily and prn (as needed). There is no date on the LNS Log noting when LNS was discontinued. Record review of the LNS Monthly Assessments for Resident #20 shows one assessment dated and signed with no credentials listed. The Nursing Progress notes dated - located in the Residents record do not describe when the brace was applied and/or removed, how long the brace is to be worn, which staff applied or removed the brace and outcome of assisting the resident with the brace at each dawning and doffing. The resident , on . 2. On during a record review of the facility's LNS log showed Resident #21 was provided LNS for " , Care" daily and prn starting with no date services were discontinued listed in the log. Record review of the LNS Monthly Assessments for Resident #21 shows one monthly assessment dated and not signed. The Nursing Progress notes dated - located in the Residents records do not describe when the , care was done and how often, what services were performed when doing , care, the outcome of the , care. On at 10:53 a.m., the Nurses Progress note states, "[Hospice] to monitor SP [status post]	AN278		

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AN278	Continued From page 42	AN278		

Cath [ ] changes."

On at 12:11 p.m., the Nurses Progress note states, "Resident had his Cath changed today by Hospice" The resident was discharged to the hospital on .

On at 8:30 a.m., during an interview, the Administrator said she didn't know why the assessments were not done or signed because she wasn't here but it is their policy to have a monthly assessment done by a nurse for all residents receiving LNS.

On at 4:30p.m., during an interview, the Wellness Director agreed that the progress notes did not reflect the services listed in the LNS log for this resident.

3. On during a record review of the facility's LNS log showed Resident #22 was provided LNS for " Care" daily and prn starting with no date services were discontinued listed in the log.

Record review of the LNS Monthly Assessments for Resident #22 shows monthly assessments dated , and and signed by an RN.

The Nursing Progress notes dated - located in the Residents records do not describe when the care was done and how often, what services were performed when doing care, the outcome of the care.

On at 4:45 p.m., the Nurses Progress note stated, "HH (Home Health) notified and came to flush tubing"

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AN278	Continued From page 43 On at 4:48 p.m., the Nurses Progress note stated, "HHSN (Home Health Skilled Nurse) to flush tubing when needed." On at 12:52 p.m., the Nurse Progress notes stated "Resident to be seen by HHSN weekly." On at 2:53 p.m., the Nurse Progress notes stated, "Cath changed a few days ago by HHSN" Nursing Progress notes from - reflect that a Home Health Nurse is providing care to the resident. The resident was discharged to the hospital on . Class III .	AN278		

Agency for Health Care Administration

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ZZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion. 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each	ZZ875		

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ZZ875	Continued From page 1	ZZ875		

employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers.
(d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues.
(e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:
1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d).
2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of , communication strategies, medical information,

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ZZ875	Continued From page 2	ZZ875		

and stress management.
3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year.
(f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request.
2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider.

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ZZ875	Continued From page 3 (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , must complete the training required in this section before , , . Proof of completion of equivalent training completed before , , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, the faiclity failed to ensure all staff completed the one hour training from the Department of Elder Affairs (DOEA) to satisfy 430.5205 F.A.C. " and Related Forms of Education and Training Act" for 3 (Staff A, C, and D) of 4 records reviewed. The findings included: Record review of employee files revealed Caregiver Staff A had a hire date of . Staff A's employee file contained no documentation of completion of the required 1-hour DOEA training video.	ZZ875		

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ZZ875	Continued From page 4 Record review of employee files revealed Caregiver Staff C had a hire date of . Staff C's employee file contained no documentation of completion of the required 1-hour DOEA training video. Record review of employee files revealed Caregiver Staff D had a hire date of . Staff D's employee file contained no documentation of completion of the required 1-hour DOEA training video. On at 10:20 a.m., during an interview, the Executive Director (ED) said there is currently no business manager, and the entire team is working on staff records. The ED said the DOEA 1 hour training is also being worked on. She said that she has gotten 18 employees to get it done and she is working on getting more of them done. The ED acknowledged that this was not the entire staff. Class III .	ZZ875		