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
	AL11968545	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DISCOVERY VILLAGE AT THE FORUM	2619 FORUM BLVD FORT MYERS, FL 33905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A relicensure, emergency power plan monitoring, health facility reporting system, visitation form and complaint investigation #2025013470 was conducted at Discovery Village at the Forum on through . Deficiencies were identified at the time of survey.	A 000		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of	A 032		

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A 032	Continued From page 1 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: Based on observation, interview, and record review, the facility failed to ensure 3 residents at risk for elopement (#20, #21, and #22) of 3 residents reviewed for elopement had identification on their person that included their name, the facility name, the facility address and phone number.	A 032		

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A 032	Continued From page 2 The findings included: Review of the facility policy "CL12 - Elopements dated , Procedure 1. Residents will be screened prior to admission, 30 days after move-in, every 6-months or in conjunction with the routine resident assessment schedule, and with significant change in resident status for significant elopement risk. . . b. i. Refer to the Admission order and FL [Florida] AHCA [Agency for Health Care Administration] for 1823 Resident Health Assessment." 1. Review of the Health Assessment Form 1823 for Resident #20 dated revealed the resident was not an elopement risk, is and needs frequent re-orientation. Resident #20's Service Description dated , page 1, revealed the "resident does not ." Resident #20 ambulates with a walker. On at 4:30 p.m., observed the memory care unit. Resident #20 was standing next to the double doors. The resident had one on the walker and one pushing on the locked double doors. The resident said she wanted to leave and go to West Virginia. The resident did not have identification on her person. On at 11:39 a.m., during an interview, the Memory Care Director said Resident #20 is at risk of elopement and is the highest risk. 2. Review of the Health Assessment Form 1823 for Resident #21 dated revealed the resident was an elopement risk and walks independently. The Senior Living Assessment dated revealed the resident intrusively.	A 032		

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A 032	Continued From page 3 On at 4:35 p.m., observed Resident #21 at memory care unit dining table. The resident did not have identification on her person. On at 11:39 a.m., during an interview, the Memory Care Director said Resident #21 was at risk for eloping from the facility when first admitted. She said they have a box of plastic identification bracelets but none of the residents wear them. 3. Review of the Health Assessment Form 1823 for Resident #22 dated revealed the resident was an elopement risk and walks with a walker. The Senior Living Assessment dated , page 1, revealed the resident intrusively. On at 4:40 p.m., observed Resident #22 in the secured memory care unit. The resident was independently throughout the dining room and the sitting area. The resident did not know her name, the date, or the place, and was not interviewable. Resident #22 did not have identification on her person. On at 11:56 a.m., during telephone interview, care giver Staff D said she works in the memory care unit, but does not check residents for identification. She said the residents don't wear any IDs. On at 2:26 p.m., during an interview, the Executive Director said every resident in the secured memory care unit is at risk of eloping and is not safe without supervision. She said each resident in memory care should be wearing an identification bracelet. The Executive Director said Resident #20's 1823 is incorrect because it	A 032		

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A 032	Continued From page 4 indicates the resident is not an elopement risk. The Executive Director said Resident #20 is an elopement risk. Class III .	A 032		
A 052 SS=D	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, 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.	A 052		

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A 052	Continued From page 5 (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 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	A 052		

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A 052	Continued From page 6 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 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	A 052		

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A 052	Continued From page 7 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, 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, interview, and record review, the facility failed to orally advise the resident on the names and doses of their medications during assistance with self-administration for 3 out of 3 residents reviewed.	A 052		

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A 052	Continued From page 8 The findings included: On at 8:26 a.m., observed Medication Technician (MT) Staff A prepare to assist Resident #17 with self-administration of 8 medications. Staff A did not orally advise the names for 5 out of 8 medications. Staff A did not orally advise the doses for 8 out of 8 medications. Staff A said to Resident #17, "I have your morning meds, , , Jardiance, and ." On at 11:00 a.m., observed MT Staff B prepare to assist Resident #18 with self administration of medications for 1 medication. Staff B said, "I have your , ." Staff B did not orally advise the resident of the dose of the , . On at 11:24 a.m., observed Staff B prepare to assist Resident #19 with self administration of medications. Staff B put the medication in the cup and handed it to the resident. The resident said, "one pill, right?" to which Staff B said yes. Staff B did not orally advise the resident of the medication name or medication dose. On at 3:00 p.m., during an interview, the Director of Health and Wellness said there was no waiver for Resident #18 and staff should be orally advising the name and the dose of the medication. The Director said Resident #17 indicated he wanted to be advised of the medications. The Director said there is a waiver for Resident #19, but the current medication list was not attached to the waiver. Class III	A 052		

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A 052	Continued From page 9	A 052		
A 053 SS=D	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record. (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including ⌣ testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care	A 053		

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A 053	Continued From page 10 Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure licensed staff assisted the resident with self-administration of medication unless an order was obtained for a nurse to administer the medications for 2 (Residents #12 and #13) of 3 residents observed for memory care unit medication pass. Further staff failed to administer medication within physician parameters for 1 (Resident #11) of 3 residents observed for memory care unit medication pass. The findings included: 1. Record review for Resident #12 revealed the resident was admitted on with diagnosis including but not limited to Unspecified, Unspecified, and Unspecified ( ). The Health Assessment Form 1823 from documented Resident #12 needed assistance with medications, not administration. No other order for the nurse to administer medications was found for Resident #12. Record review for Resident #13 revealed the resident was admitted on with diagnoses including type II, , Hypoosmolality and Hyponatremia, unspecified severity with agitation, and . The Health Assessment Form 1823 dated documented Resident #13 needed assistance with medications, not administration. No other order for the nurse to administer medications was	A 053		

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A 053	Continued From page 11 found for Resident #13. Observation of the medication pass on at 8:36 a.m., found Licensed Practical Nurse (LPN) Staff C administer medications by spooning the medications from the pill cup into Resident #12's . Resident #12 was eating her lunch. Further observation of the medication pass found LPN Staff C was administer medications by spooning the medication from the pill cup into Resident #13's . On at 8:50 a.m., during an interview, the LPN Staff C said, "If you set it in front of them, they won't take it. It just sits there. We spoon feed [medications to] everyone. 2. Observation of the medication pass on for Resident #11 observed LPN Staff C set up medications for Resident #11. When LPN Staff C got to the 5 mg to be given 1-tab 2 times daily, hold if (, ,) is greater than 140, she stopped and took Resident #11's which LPN Staff C reported as . LPN Staff C said she would hold the medication. LPN Staff C withheld the medication even though the residents , was not over 140. On at 8:30 a.m., during an interview, LPN Staff C said, I know it says 140 but we usually hold at 130. She verified the parameters had not been changed with the physician. Class III .	A 053		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders	A 056		

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A 056	Continued From page 12	A 056		

(7) MEDICATION LABELING AND ORDERS.
(a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:
1. The resident's name; and,
2. The identification of each medicinal drug in the container.
(b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another.
(c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.
(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by

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A 056	Continued From page 13	A 056		

the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.
(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.
(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.
(g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following:
1. Practitioner's name,
2. Resident's name,
3. Date dispensed,
4. Name and strength of the drug,
5. Directions for use; and,
6. Expiration date.
(h) Pursuant to Section 465.0276(2)(c), F.S.,

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DISCOVERY VILLAGE AT THE FORUM	2619 FORUM BLVD FORT MYERS, FL 33905

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 056	Continued From page 14 before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on record review, observation, and interview, the facility failed to ensure over-the counter or prescribed medications for which the order had changed had an alert sticker on the label or a new pharmacy label and further failed to ensure the label included all parameters for dispensing for 1 (Resident #12) of 3 residents reviewed for medications in the Memory Care unit. The findings included: Record review for Resident #12 revealed the resident was admitted on with diagnosis including but not limited to Unspecified, Unspecified, and Unspecified ( ). Observation of the medication pass on at 8:28 a.m., found Resident #12 had a bottle of 81 mg. The bottle was labeled only with the manufacturers directions which stated, "adults and children and older take 4 to 8 tablets every 4 hours not to exceed 48 tablets in 24 hours unless directed by a doctor." The bottle also showed it expired on . Observation found Licensed Practical Nurse (LPN) Staff C poured 1 tablet into the pill cup. LPN Staff C then added 1 tablet of 5mg. The label on the bottle had said " 10 mg, take 1 tablet by twice a day." The label was noted to be altered	A 056		

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A 056	Continued From page 15 as the "10 mg" was inked out and "5" written in, also "twice a" was inked out and "daily" was written in. The bottle was noted to have been filled on and expired on . A review of the Medication Observation Record (MOR) revealed the ( ) low tab 81 MG ( ) Take one tablet by every day - DX (diagnosis) . The MOR also documented 5 mg tab, 1 5 mg tab daily. During an interview on at 9:15 a.m., the LPN Staff C said the spouse obtained and brought the medications to the facility. LPN Staff C said the husband had altered the bottle before he brought the medications in. She said, "Normally the night shift checks the expiration dates. The night shift was supposed to remove expired medications from the carts, but its all our responsibility to check." Class III .	A 056		
A 078 SS=E	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have 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	A 078		

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A 078	Continued From page 16 when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to 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	A 078		

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A 078	Continued From page 17 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 that within 30 days of employment, staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable for 2 (Director of Health and Wellness, and Executive Director) out of 4 records reviewed. The findings included: On , record review of employee files revealed that the Executive Director (ED) had a hire date of . Further review of the ED's employee file showed documentation of freedom of signs/symptoms of communicable dated . The records show that the documentation was beyond 6 months prior to hire. ** Photographic Evidence Obtained ** On , record review of employee files revealed that the Director of Health and Wellness	A 078		

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A 078	Continued From page 18 (DOHW) had a hire date of . Further review of the DOHW's employee file showed documentation of freedom of signs/symptoms of communicable dated . The records show that the documentation was beyond 6 months prior to hire. ** Photographic Evidence Obtained** On at 11:35 a.m., during an interview, the Executive Director said that she thought that the communicable statement was a one-time statement that you could carry along from one facility to another. She acknowledged that the statements were outside the regulation. Class III .	A 078		

Agency for Health Care Administration

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ZZ875 SS=E	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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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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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 facility failed to satisfy 430.5205 Florida Administrative Code " and Related Forms of Education and Training Act" ensuring all staff completed the one hour training video from the Department of Elder Affairs (DOEA) for 2 (Director of Health and Wellness, Executive Director) out of 4 records reviewed. The findings included: On , record review of employee files revealed that the Director of Health and Wellness had a hire date of . The Director of Health and Wellness's employee file contained no	ZZ875		

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ZZ875	Continued From page 4 documentation of having completed the required 1-hour DOEA training video. On , record review of employee files revealed that the Executive Director had a hire date of . The Executive Director's employee file contained no documentation of having completed the required 1-hour DOEA training video. On at 10:50 a.m., during an interview, the Executive Director said that she would try to get her DOEA training certificate from her prior facility. She said she was not sure of the Director of Health and Wellness and that I should check in the Business Office. On at 10:53 a.m., during an interview, the Business Office Director said to her knowledge there is nothing else outstanding that is not in those files, so they should be current and have all the necessary documentation. She said the DOEA training is required but if it is not in the file it has not been done, and that includes all staff. On at 11:35 a.m., during an interview, the Executive Director acknowledged that she and the Director of Health and Wellness did not complete the required DOEA training. Class III .	ZZ875		