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
	AL11969411	A. BUILDING: _____ B. WING _____	11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LIVING OF DAVIE LLC	2794 SOUTH FLAMINGO ROAD DAVIE, FL 33330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Relicensure, Complaint (2024014915, 2025009303), Limited Nursing Services (LNS) and Generator Monitoring survey was conducted at Artis Senior Living of Davie LLC on . The facility had deficiencies related to the Relicensure and LNS survey at the time of the visit.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is	A 008		

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A 008	Continued From page 1 performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident	A 008		

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A 008	Continued From page 2 which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care practitioner as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 days before or within 30 days after the individual's admission to a facility pursuant to Section 429.26(5), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or , , services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of , , , or any other communicable , which are likely to be	A 008		

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A 008	Continued From page 3 transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care practitioner, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care practitioner. (b) When a health care practitioner conducts a medical examination, the examination must be recorded on the practitioner's form or on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-13531. Faxed or electronic copies of the completed form are acceptable. If AHCA Form 1823 is used, the form must be completed as instructed. 1. If the health care practitioner's form does not include all the examination items on AHCA Form 1823 or if AHCA Form 1823 is not completed fully, then the omitted items may be obtained by the administrator or designee either orally or in writing from the health care practitioner. The missing or omitted information must be obtained and documented in the resident's record within 30 days after the resident's admission to the facility. 2. Omitted or missing information received orally must include the name of the health care practitioner, the name and signature of the administrator or designee recording the information, and the date the information was provided. (c) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30	A 008		

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A 008	Continued From page 4 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (d) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of Section 429.26, F.S. and this rule. (e) Any orders issued by the health care practitioner conducting the medical examination for medications, nursing services, treatments, , , or therapeutic diets, may be attached to the health assessment. A health care practitioner may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or , (f) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on review of policy and procedure, record review and interview, the facility failed to ensure that it maintained a complete and updated 1823 Agency for Healthcare Administration (AHCA) Health Assessment Form for 2 of 3 sampled residents reviewed, Resident #13 and Resident	A 008		

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A	Continued From page 5 #10. The findings included: Review of the facility policy titled Residency Agreement provided by the Director of Health and Wellness (DHW) revised documented in the Policy Statement: ....Residents to, "agree to have a Medical evaluation by a Physician, recorded on the AHCA form 1823 ....no more than thirty (30) days prior to commencement of residency and annually thereafter ....an updated medical evaluation indicates .....the Resident's personal care needs ....condition changes ... ... 1) Resident #13 moved-into the facility on with diagnoses which included , Hematoma (SDH) , Adult and Mild . Her Status is listed as: and Agitation. On the most recent Physician's Order documented, " Lower (BLE) , Stockings. Apply in morning, remove in evening." Record review of the Resident #13's current Individual Service Plan dated documented, for " , Hose that, "Resident requires standby/physical assistance in the AM/PM with , / ." However, record review of the most recent 1823 AHCA Health Assessment for Resident #13 revealed that it was both incomplete, with an "un-dated," Examiner signature page. Further record review of the Nursing/Treatment/ , , Service Requirements section of the 1823 AHCA Form	A 008		

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A 008	Continued From page 6 was also "left blank." A side-by-side record review (and interview) was conducted on at 11:18 AM with the DHW, in which she acknowledged that the AHCA Assessment Form section was incomplete and that the Examiner signature page had been "un-dated." 2) Resident #10 moved-into the facility on with diagnoses which included , , ( ) and History of , , , , , ( ). He was alert and oriented to person, place and time. On the most recent Physician's Order documented, "BLE , Stockings. Apply in morning, remove in evening/Apply Continuous Positive Airway Pressure (CPAP) before bed and remove in morning." Record review of the Resident #10's Individual Service Plan dated documented, for " , Hose that, "Resident requires standby/physical assistance in the AM/PM with , / ." And, for "Assistive , , Devices---Resident requires a CPAP/ Bilevel Positive Airway Pressure (BIPAP) machine." However, record review of the most recent 1823 AHCA Health Assessment for Resident #10 revealed that the section area titled Nursing/Treatment/ , , Service Requirements section, had not been updated to include the presence of the resident's , Stockings and of his CPAP machine. A side-by-side record review and interview was	A 008		

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A 008	Continued From page 7 conducted on at 11:25 AM with the DHW, in which she acknowledged that the AHCA Assessment Form section for Resident #10 had not been updated. During a telephone interview conducted on at 5 PM with the Registered Nurse/Limited Nursing Supervisor (RN/LNS), it was also reported to her that Resident #13 and Resident #10, both LNS residents, have 1823 AHCA Health Assessment Form documents had not been updated, nor complete. And, her only response to what was reported to her was, "Ok, I will have to look into it." The DHW further recognized and acknowledged on at 5:18 PM that the 1823 AHCA Health Assessment Form documents, for both residents should have been updated and should not have been "un-dated," and incomplete. Class III	A 008		
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	A 010		

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A 010	Continued From page 8 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, 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,	A 010		

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A 010	Continued From page 9 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 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)	A 010		

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A 010	Continued From page 10 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 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	A 010		

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A 010	Continued From page 11	A 010		

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 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 interview and observation, the facility failed to ensure that the Health Assessment was completed/or updated following a substantial change for 1 of 3 Residents reviewed (Resident #5).

The findings include:

A review of Resident #5's facility Demographic/ Sheet documented that he was admitted to the facility on .

A review of Resident #5s facility files and documents revealed a Resident Health Assessment (AHA Form 1823) dated documented the Resident's diagnosis to include: and , , , Presence of ( )

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A 010	Continued From page 12 of , Retention of . It also documented the Resident had Catheter and required Nursing services as required by physician. In an interview with the Director of Health and Wellness, Staff E on at 1:47 PM she stated Resident #5 does not have a ( ) and did not move into the facility with a . She was informed that the Resident's 1823 documented he had a . She restated that he did not have one upon moving in. No additional information was provided during the interview. In an interview with Resident #5 on at 3:59 PM he stated to the surveyors that he no longer has a , as he didn't need it. Observation of Resident #5 during the interview did not reveal any obvious signs of having an external apparatus. In an interview with the Administrator and the Director of Health and Wellness on 11/03/2025 at 5:07 PM they were informed/or reminded that the an updated 1823 must be completed when a substantial change occurs with a resident. They acknowledged. Class III	A 010		
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.	A 053		

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A 053	Continued From page 13 (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 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 review of policy and procedure, observation, record review and interview, the facility failed to follow standard guidelines for 2 of 8 sampled residents observed during an observation of a resident's Assistance with Self-Administered Medication (Resident #19 and	A 053		

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	AL11969411	A. BUILDING: _____ B. WING _____	11/03/2025

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A 053	Continued From page 14 Resident #5). The findings included: Review of the facility policy titled Medication Management provided by the Director of Health and Wellness (DHW) reviewed documented in the Policy Statement: It is the policy of this residence that medication management and administration is performed by staff authorized by Artis standards and State regulations, in accordance with current physician orders and acceptable administration practices ....Procedures ...3. The DHW will provide oversight for medication management and administration for all residents. 1) Resident #19 moved-into the facility on with diagnoses which included and . Her Status is listed as awake, alert, oriented x1. An "Assistance with a Self-Administered Medication Observation" was conducted on at 12:52 PM for Resident #19, by Staff F, Medication Technician. During the Medication Pass, Resident #19 was observed as disoriented and having to be cued and prompted multiple times by Staff F, in order to try to have the resident to take and hold her , medication bottle. Next, Staff F proceeded to "physically" place her right over the "un-aware" resident's left (in which the , bottle had been placed). Then, Staff F proceeded to try and "administer" the , medication in this " -over- " manner or technique into the resident's left , in the presence of this Nurse	A 053		

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A 053	Continued From page 15 Surveyor; Resident #19 ultimately refused her , , medication, during this time. During an interview conducted on at 1:07 PM with Staff F, Staff F revealed to this Nurse Surveyor, that she has always utilized the exact same " -over- ," method/technique in providing the resident with her , , medication. Staff F also revealed that Resident #19 had never been able to hold the , , bottle, in her own . Furthermore, Staff F also acknowledged that for a total of sixteen (16) times, as revealed in corresponding documentation and as on both the and Medication Observation Record (MOR), by Staff F's initials, that she did do a physical " -over- " motion technique action with the "un-aware, resident in order to provide medications to her. On the Physician's Order documented, " 1%-0.2% , , to instill one (1) drop into left , three (3) times daily for increased , pressure." Record review of the Resident #19's Individual Service Plan dated: documented and captured under Section 5. Medications and Treatments---1. Medication Management - Level of Assistance, "Resident requires more , assistance ...and/or three (3) or more med passes a day." Record review of the most recent 1823 AHCA Health Assessment dated "Section 2. Self-Care and General Oversight Assessment - Medications," documented, "Needs Assistance with Self-Administration (this allows unlicensed staff to assist with , , , oral, , and , medications."	A 053		

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A 053	Continued From page 16 However, there was no evidence documented to show that Resident #19's Medication status had been re-assessed, nor that her 1823 AHCA Health Assessment had been updated to reflect any current changes, or the "potential" need for "Medication Administration", rather than only assistance with her Self-Administered medications. Record review of the MOR for the month of and showed that there was corresponding documentation, as evident by Staff F's initials, reviewed. An interview and (side-by-side record review) with DHW on at 1:53 PM in which she acknowledged that the most recent 1823 Health Assessment dated had not been updated to reflect that the resident now required Medication Administration, rather than only assistance with her Self-Administered medications. 2) Resident #5 admitted the facility on with diagnoses which included , Major . His Status is listed as Alert with and memory . During an interview with Staff F (Med tech) on at 08:42 AM, the Staff was questioned on how she provides Spray medication (, Spray, " " 50 mcg) to Resident #5, Staff F stated, she provides the resident instructions on how to do Spray. An "Assistance with a Self-Administered Medication Observation" was conducted on	A 053		

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A 053	Continued From page 17 at 8:35 AM for Resident #5 by Staff F, Medication Technician. During the Medication Pass, Resident #5 was observed as disoriented and having to be cued and prompted multiple times by Staff F, in order to try to have the resident to take and hold his spray medication bottle (, , Spray, " " 50 mcg). Next, Staff F proceeded to "physically" place her right over the "un-aware" resident's right (in which the spray bottle had been placed). Then, Staff F proceeded to try and "administer" the spray medication in this " -over- " manner or technique into the resident's right and left Nostril Holes, in the presence of the Surveyor. Record review of the most recent 1823 AHCA Health Assessment dated "Section 2. Self-Care and General Oversight Assessment - Medications," documented, "Needs Assistance with Self-Administration (this allows unlicensed staff to assist with , , , oral, , and , medications." However, there was no evidence documented to show that Resident #5's Medication status had been re-assessed, nor that her 1823 AHCA Health Assessment had been updated to reflect any current changes, or the "potential" need for "Medication Administration", rather than only assistance with her Self-Administered medications. Record review of the MOR for the month of and showed that there was corresponding documentation, as evident by Staff F's initials, reviewed. The DHW further recognized and acknowledged	A 053		

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A 053	Continued From page 18 on at 2:16 PM that the Med. Tech. should not have been "administering" medications to this resident and that the resident should have been "re-assessed" for her Medication status, with the 1823 AHCA Health Assessment updated, as applicable. Class III	A 053		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (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	A 056		

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A 056	Continued From page 19 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 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	A 056		

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A 056	Continued From page 20 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., 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 observation, record review and interview, it was determined that the facility failed to review the Medication Observation Record (MOR) and medication label to ensure they were within parameters (time/or dosage) for 4 out of 7 sample residents (Resident#5,6,9 and 10). The findings include: 1). On at 7:38 AM Staff B, Facility Nurse, was observed providing self-administration of medication to Resident #9. Observation during the medication pass revealed Resident #9 was given the following: a). Polyethylene Glyco PWD (238) 17 grams by twice weekly AM to be dissolved in 8 ounces of liquid, as indicated by the Medication Observation Record (MOR) and label.	A 056		

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A 056	Continued From page 21 Observation of the medication pass revealed Staff B used a 5-ounce cup to dissolve the medication instead of an 8-ounce cup. b) , 0.5 mg tablet, take one tablet by every morning at 9:00 AM. Observation of the medication pass at 7:38 AM revealed the medication was given to the resident. During an interview with Staff E, Director of Health and Wellness on 11/03/2025 at approximately 9:55 AM, the surveyor asked her to confirm how many ounces of water was in the blue cup that was used to dissolve the Polyethylene Glyco PWD during the medication pass. She stated five (5) ounces were used. Staff E was informed that Staff B had administered medication (, 0.5 mg) at 7:38 AM instead of 9:00 AM. Staff E acknowledged the findings. During a medication pass on at 7:48 AM, Staff B (Facility Nurse) was observed providing assistance with self-administration of medication to Resident #10; Jardiance 10 mg tablet. A review of the Medication Observation Record (MOR) and label documented the medication was to be once daily by during breakfast. During an interview on at 7:54 AM with the surveyor, Resident #10 was asked if he had breakfast. He stated at that time he had not. 2). During an interview with Staff B on 11/03/2025 at approximately 8:10 AM, she was asked by the surveyor why she is not following parameters (time/dosage), she provided no direct response but acknowledged the findings.	A 056		

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A 056	Continued From page 22 a). During Med-Pass observation on at 8:35 AM, this surveyor observed Staff F assisting Resident #5 with self-administration of medication. Review of the Medication Observation Record (MOR) and label Observation revealed he was to be given 325 MG by once daily with breakfast. b). Observation of Resident #5 on at 8:41 AM revealed he was sitting in the dining room drinking orange juice. This surveyor attempted an interview with the resident but was unable to get a response. Resident #5 has a diagnosis of , and . Further observation of Resident #5 revealed he received his food at 8:57 AM (only a fruit cup), approximately 22 minutes after receiving his medication. During Med-Pass observation on at 8:45 AM, this surveyor observed Staff F assisting Resident #6 with self-administration of medication. Review of the Medication Observation Record (MOR) and label Observation revealed he was to be given 25mg (25mg) Tablet by twice daily, 500 MG by twice daily with meals. On at 8:41 AM Resident #6 was observed sitting in the dining room drinking orange juice. The Resident received his food (a fruit cup) at 8:58 AM. In an interview with Staff F, MedTech, on at 8:42 AM this surveyor asked when breakfast is served. She stated it is usually served at 8:45 AM daily. No additional information was provided relating to Resident #5 and 6 not receiving their medication(s) during meals as ordered.	A 056		

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A 056	Continued From page 23 Class III Based on observation, record review and interview, it was determined that the facility failed to review the Medication Observation Record (MOR) and medication label to ensure they were within parameters (time/or dosage) for 4 out of 7 sample residents (Resident#5,6,9 and 10). The findings include: 1). On at 7:38 AM Staff B, Facility Nurse, was observed providing self-administration of medication to Resident #9. Observation during the medication pass revealed Resident #9 was given the following: a). Polyethylene Glyco PWD (238) 17 grams by twice weekly AM to be dissolved in 8 ounces of liquid, as indicated by the Medication Observation Record (MOR) and label. Observation of the medication pass revealed Staff B used a 5-ounce cup to dissolve the medication instead of an 8-ounce cup. b) , 0.5 mg tablet, take one tablet by every morning at 9:00 AM. Observation of the medication pass at 7:38 AM revealed the medication was given to the resident. During an interview with Staff E, Director of Health and Wellness on 11/03/2025 at approximately 9:55 AM, the surveyor asked her to confirm how many ounces of water was in the blue cup that was used to dissolve the Polyethylene Glyco PWD during the medication pass. She stated five (5) ounces were used. Staff E was informed that Staff B had administered medication (, 0.5 mg) at 7:38 AM instead of 9:00 AM. Staff E acknowledged the	A 056		

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A 056	Continued From page 24 findings. During a medication pass on at 7:48 AM, Staff B (Facility Nurse) was observed providing assistance with self-administration of medication to Resident #10; Jardiance 10 mg tablet. A review of the Medication Observation Record (MOR) and label documented the medication was to be once daily by during breakfast. During an interview on at 7:54 AM with the surveyor, Resident #10 was asked if he had breakfast. He stated at that time he had not. 2). During an interview with Staff B on 11/03/2025 at approximately 8:10 AM, she was asked by the surveyor why she is not following parameters (time/dosage), she provided no direct response but acknowledged the findings. a). During Med-Pass observation on at 8:35 AM, this surveyor observed Staff F assisting Resident #5 with self-administration of medication. Review of the Medication Observation Record (MOR) and label Observation revealed he was to be given 325 MG by once daily with breakfast. b). Observation of Resident #5 on at 8:41 AM revealed he was sitting in the dining room drinking orange juice. This surveyor attempted an interview with the resident but was unable to get a response. Resident #5 has a diagnosis of , and . Further observation of Resident #5 revealed he received his food at 8:57 AM (only a fruit cup), approximately 22 minutes after receiving his medication.	A 056		

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A 056	Continued From page 25 During Med-Pass observation on at 8:45 AM, this surveyor observed Staff F assisting Resident #6 with self-administration of medication. Review of the Medication Observation Record (MOR) and label Observation revealed he was to be given 25mg (25mg) Tablet by twice daily, 500 MG by twice daily with meals. On at 8:41 AM Resident #6 was observed sitting in the dining room drinking orange juice. The Resident received his food (a fruit cup) at 8:58 AM. In an interview with Staff F, MedTech, on at 8:42 AM this surveyor asked when breakfast is served. She stated it is usually served at 8:45 AM daily. No additional information was provided relating to Resident #5 and 6 not receiving their medication(s) during meals as ordered. Class III	A 056		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have 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.	A 078		

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A 078	Continued From page 26 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 and the staffing agency or contractor must specifically describe the services the staffing	A 078		

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(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 078	Continued From page 27 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 2 of 4 sampled employees (Staff A, and B) had a negative ( ) statement signed by a health care provider as required annually. The findings include: 1) Review of the facility's personnel file for Staff A (Administrator) revealed a hire date of . The review revealed that Staff A's most recent negative ( ) statement was dated . Further review of his file no update documentation of annual a negative . 2) Review of the facility's personnel file for Staff B (Facility Nurse) revealed a hire date of . The review revealed that Staff B's last negative was dated . Further review of her file revealed no update documentation of annual a negative . During an interview with the Administrator on at approximately 4:35 PM he acknowledged the findings. No additional documentation was provided during the survey.	A 078		

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	AL11969411	A. BUILDING: _____ B. WING _____	11/03/2025

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A 078	Continued From page 28 Class III	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice	A 081		

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A 081	Continued From page 29 training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of	A 081		

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A 081	Continued From page 30 compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty	A 081		

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A 081	Continued From page 31 (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure direct care staff had completed the required inservice trainings, for 2 of 4 sampled staff (Staff C, and D). The findings include: 1) Review of the personnel file for Staff C (Caregiver) with a hire date of . Staff C Preservice Orientation Training, Elopement Response Training, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting Training in her employee file. 2) Review of the personnel file for Staff D (Caregiver) with a hire date of . Staff D had ADL and Behavioral Needs Training dated through for one (1) hour instead of three (3) hours and Nutritional and Safe Food Handling training in his employee file. During an interview on at approximately 4:35 PM the Administrator was informed of the findings mentioned above. No	A 081		

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A 081	Continued From page 32 additional documentation was provided during the survey. 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 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, it was determined that, the facility failed to ensure that within 30 days of employment staff obtained required training for / , (/) for 1 of 4 sample staff (Staff C). The findings include: Review of the personnel file for Staff C (Caregiver) with a hire date of . Staff C did not have documentation for / training in her personnel file. During an interview on at approximately 4:35 PM the Administrator acknowledged the findings. No additional	A 082		

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A 082	Continued From page 33 documentation was provided during the survey. Class III	A 082		
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 1 of 4 employees (Staff C) had completed ( ) Policy and Procedure training. The findings include: Review of the personnel file for Staff C (Caregiver) with a hire date of . Staff C did not have documentation for Training in her employee file. During an interview on at approximately 4:35 PM the Administrator was informed of the findings mentioned above. No	A 090		

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A 090	Continued From page 34 additional documentation was provided during the survey. Class III	A 090		
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 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.	AN277		

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AN277	Continued From page 35 This Statute or Rule is not met as evidenced by: Based on review of policy and procedure, observation, record review and interview, the facility failed to follow Resident Care Standards for 1 of 2 sampled residents reviewed for Limited Nursing Services (LNS), Resident #13. The findings included: Review of the facility policy titled Elder Affairs State of Florida - Florida Affordable Assisted Living - Limited Nursing Services (LNS) License provided by the Director of Health & Wellness (DHW) reviewed 2011 documented in the Policy Statement: A LNS license is a specialty license that enables a facility to provide a select number of nursing services. Residents of facilities licensed to provide LNS services are required to meet the standard Assisted Living Facility (ALF) admission criteria. However, in addition to the standard licensed facilities, facilities holding an LNS license may provide, directly or through contract, the following limited nursing services ....Assisting, applying, caring for and monitoring the application of stockings or hosiery as prescribed by the health care provider manufacturer's guidelines ..... Resident #13 moved-into the facility on with diagnoses which included , Hematoma (SDH) , Adult and Mild . Her Status is listed as: and Agitation. During an observation conducted on at 11:35 AM of Resident #13, she was observed sitting up in her wheelchair in the Activities Room. However, she was observed wearing only her	AN277		

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AN277	Continued From page 36 "short" sock footies, at the time, but not her lower extremity , stockings, as ordered. On at 11:30 AM, an interview was conducted with Staff I, Certified Nursing Assistant. Staff I acknowledged that Resident #13 did have both a pair of longer hi stockings, and a pair of shorter hi , stockings. Staff I revealed that Resident #13 had not been wearing her , stockings when she began her shift at 7AM. And, Staff I also revealed that the "ordered" , stockings had not been put on the resident by her, until later just before lunch that day. On at 11:30 AM, an observation was conducted of Resident #13's room, with the DHW, and it was revealed that the resident had a pair of both her longer hi stockings, and her shorter hi , stockings, both of which were present in the resident's top dresser drawer. Record review of the Physician's prescription dated for Resident #13's, documented, " lower extremity , Stockings apply in the morning remove in evening." Further record review of the Resident #13's current Individual Service Plan dated documented, for " , Hose that, "Resident requires standby/physical assistance in the AM/PM with , / ." During a telephone interview conducted on at 5 PM with the Registered Nurse/Limited Nursing Supervisor (RN/LNS), it was also reported to her that Resident #13, had not been wearing her lower extremity	AN277		

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AN277	Continued From page 37 , stockings, as ordered. And, her only response to what was reported to her was, "Ok, I will have to look into it." The DHW further recognized and acknowledged on at 5:12 PM that the resident had not been wearing her ordered Lower Extremity , stockings and she added that the resident should have been wearing them, as ordered. 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 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 review of policy and procedure,	AN278		

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AN278	Continued From page 38 observation, record review and interview, the facility failed to conduct and document monthly assessments, and maintain descriptive and specific progress notes for 2 of 2 sampled residents reviewed for Limited Nursing Services (LNS), Resident #13 and Resident #10. The findings included: Review of the facility policy titled, Limited Nursing Services (LNS) provided by the Director of Health & Wellness revised documented in the Policy Statement: Artis Senior Living will follow the LNS Standards for providing care under its license. Procedure: ...5. A Monthly assessment will be completed for each resident by a qualified RN ....8. Any changes will be reviewed and progress notes pertaining to the service provided will be included in the resident's medical record .... #1) Resident #13 moved-into the facility on with diagnoses which included , Hematoma (SDH) , Adult and Mild . Her Status is listed as: and Agitation. On the most recent Physician's Order documented, " Lower (BLE) , Stockings. Apply in morning, remove in evening." Record review of the Resident #13's current Individual Service Plan dated documented, for " , Hose that, "Resident requires standby/physical assistance in the AM/PM with , / ." However, further record review revealed that there had only been one (1) monthly assessment	AN278		

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AN278	Continued From page 39 completed dated: . There were no monthly LNS assessments completed for this resident for the months of: , thru . According to the LNS Nursing progress notes dated thru ; only two (2) of the progress notes dated and , even referenced Resident #13's ordered , stockings. #2) Resident #10 moved-into the facility on with diagnoses which included , , ( ) and History of , , , , ( ). He was alert and oriented x3. On the most recent Physician's Order documented, "BLE , Stockings. Apply in morning, remove in evening/Apply Continuous Positive Airway Pressure (CPAP) before bed and remove in morning." Record review of the Resident #10's Individual Service Plan dated documented, for " , Hose that, "Resident requires standby/physical assistance in the AM/PM with , / ." And, for "Assistive , Devices---Resident requires a CPAP/ Bilevel Positive Airway Pressure (BIPAP) machine." However, further record review of the LNS Nursing progress notes dated thru did not indicate any description regarding either the resident's CPAP, nor of Resident #10's Lower Extremity , Stockings. There were no monthly LNS assessments completed for the months of , thru	AN278		

Agency for Health Care Administration

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AN278	Continued From page 40 During a telephone interview conducted on at 5 PM with the Registered Nurse/Limited Nursing Supervisor (RN/LNS), it was also reported to her by this Nurse Surveyor regarding for Resident #13 and Resident #10, that the monthly LNS assessments had not been done, nor had the Nursing progress notes, been descriptive and specific as pertained to LNS services. And, her only response to what was reported to her was, "Ok, I will have to look into it." The DHW further recognized and acknowledged on at 5:28 PM that the monthly LNS assessments should have been done, and the Nursing progress notes should be both descriptive and specific as pertained to LNS services. Class III	AN278		

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ZZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's 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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	AL11969411	A. BUILDING: _____ B. WING _____	11/03/2025

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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 's 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 's , communication strategies, medical information,

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ZZ875	Continued From page 2 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 's 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.	ZZ875		

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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 ensure that staff completed the 1-hour video training; and annual completion of four (4) hours of continuing education for 4 of 4 staff reviewed (Staff A,B, C and D). The findings include: 1) A review of Staff A (Administrator) file and documents revealed that he was hired on . The review also revealed the file did not have documentation that he had taken the 1-hour video training in his file. Further review revealed the last training of the annual completion of four (4) hours of continuing	ZZ875		

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ZZ875	Continued From page 4 education was dated . Staff A did not have continuing education for the year 2025 in his file. 2) A review of Staff B (Facility Nurse) file and documents revealed that she was hired on . The review also revealed the file did not have documentation that she had taken the 1-hour video training in her file. Further review revealed the last training for the annual completion of four (4) hours of continuing education was dated . Staff B did not have continuing education for the years 2024 and 2025 in her file. 3) A review of Staff C (Caregiver) file and documents revealed that she was hired on . The review also revealed that Staff C did not have documentation that she had taken the 1-hour video training. Further review revealed the last training for the annual completion of four (4) hours of continuing education was dated . Staff C did not have continuing education for the year 2025 in her file. 4) A review of Staff D (Caregiver) file and documents revealed that she was hired on . The review also revealed that Staff D did not have documentation that she had taken the 1-hour video training. Further review revealed last training for the annual completion of four (4) hours of continuing education was dated . Staff D did not have continuing education for the years 2024 and 2025 in her file. In an interview with the Administrator on at 4:30 PM he was informed/or reminded that documentation of the four (4) hour	ZZ875		

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ZZ875	Continued From page 5 training for Staff A, B, C and D was not in their files. No documentation was provided during the survey. Class III	ZZ875		