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
	AL11969459	A. BUILDING: _____ B. WING _____	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE LIVING AT HUNTER'S CREEK	1701 BALL PARK RD KISSIMMEE, FL 34741

(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
ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

AHCA Form 3020-0001

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

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic ⌄ , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 8 sampled staff (B) had a new level 2 background screening after having had a break in service from a position that required level 2 screening for more than 90 days. Findings: A review of caregiver B's personnel record revealed a hire date of . A review of the caregiver's background screening revealed she was last eligible on . A review of the caregiver's employment application, dated , revealed her most recent position that required level 2 background screening ended , . Therefore, a new background screening was required. During an interview on at 12:13 PM, the	ZZ814		

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ZZ814	Continued From page 2 Business Office Manager confirmed the findings and said she was unaware of the new screening requirement following a 90-day break in service. Unclassified	ZZ814		
A 000	Initial Comments A re-licensure survey with Limited Nursing Service (LNS), a complaint investigation (2025013514, 2025014072,) and generator monitoring were conducted at Providence Living at Hunter's Creek on , , and . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making . , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the	A 025		

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A 025	Continued From page 3 condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services to meet the needs of 1 of 7 sampled residents (#1) who was not assessed for injuries	A 025		

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A 025	Continued From page 4 after being found on the floor and failed to ensure a health care provider's order was followed when a medication was not given at the right time to 1 of 7 sampled residents (#15). Findings: 1. A review of resident #1's record revealed a facility admission date of . The residents' medical history included advanced , , , functional , , , and . A review of a health assessment form (1823,) dated , revealed the resident was a risk. A review of a facility note, dated , revealed a was observed on the resident's right upper arm. Continued review of the residents' records found no documented cause of the . A review of a health care provider's note, dated , revealed extensive was seen on the resident's left arm, right arm, and right area. The note indicated the cause was unexplained as there was no reported and that an would be ordered. A review of the results, dated , revealed the presence of severe right . Observations made on at 9:56 AM, revealed resident #1 was lying in her hospital bed. Both half-side rails were up. The resident was alert and occasionally made contact. Except for occasional verbal noises, she was otherwise nonverbal.	A 025		

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A 025	Continued From page 5 During an interview on at 9:37 AM, caregiver A said that on at around 4 PM the resident was found on the floor in her room with red on her arm. Caregiver A said that she and another caregiver put the resident in her bed. Caregiver A said that someone told the nurse on duty, but she did not know who. During an interview on at 9:50 AM, nurse F, who worked on from 7 AM to 7 PM, said that no one told her the resident was found on the floor and no one told her about the . The nurse said she had no reason to look at the resident's skin that day to have seen herself. During an interview on at 10:05 AM, the Memory Care Coordinator, who worked on from 3 PM to 11 PM, said she was unaware of the resident having a during the shift. She went on to say that she recalled hearing on that a did occur at some time and the resident was put in bed. During an interview on at 10:57 AM, caregiver A said that after reviewing her work schedule, she remembered the resident was found on the floor on at around 6 AM. Caregiver A said she and caregiver G put the resident in her bed. Caregiver A said that the resident did not yell out or give other non-verbal signs of , . Caregiver A said she did not see at that time. Caregiver A went on to say the resident put herself on the floor all the time, which was why she needed the hospital bed. Caregiver A said a nurse did not work from 7 PM to 7 AM. Caregiver A said that if a nurse was on duty, they had to be informed of a . Otherwise, they were told when they arrived at 7	A 025		

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A 025	Continued From page 6 AM. Caregiver A said she did not report the incident to the nurse who came on duty at 7 AM or to a supervisor because she had to go home and go to sleep to return at 3 PM. A review of the policy, revised , revealed that when a resident the caregiver was instructed to summon immediate assistance from the nurse or another caregiver. The policy indicated the caregiver was not to move the resident, except to protect against further injury, as in the case of a dangerous environment. During an interview on at 11:20 AM, the Memory Care Coordinator clarified that she was the manager on duty on from 7 AM to 3 PM. She said that it was during that shift when she heard the resident was picked up off the floor. She went on to say she did not know if the incident was reported to a nurse or health care provider when it occurred. She also said that when a caregiver found a resident on the floor, they were required to notify the Wellness Director, who would then instruct them further. During an interview on at 1:41 PM, the Wellness Director said she did not interview staff who worked prior to about the injuries because she learned about the injuries herself on . During an interview on at 1:55 PM, the Business Office Manager said caregivers A and G were not trained in the facility's policy. During an interview on at 5:51 PM, caregiver G said that on at about 5 AM, she went into the resident's room to check on her and found her lying on her side on the floor. Caregiver G said she went to the nurse's office	A 025		

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A 025	Continued From page 7 but could not find a nurse. Caregiver G said she found caregiver A, who accompanied her to the resident's room. Caregiver G said that she and caregiver A placed a towel under the resident then used it to aid them in putting the resident in her bed. Caregiver G said that when they did so, the resident screamed a tiny bit. Caregiver G said that once the resident was in her bed, caregiver A left and caregiver G dressed the resident then put her in her wheelchair. Caregiver G said that during this process, the resident showed no verbal or non-verbal signs of , . Caregiver G said she did not see a at that time. Caregiver G said the policy was that when a resident was found on the floor the caregiver must first call a nurse before touching the resident. Caregiver G said that she and caregiver A placed the resident in bed because they could not leave her on the floor. Caregiver G said she forgot to tell management about the incident. During an interview on at 10:34 AM, the Administrator and the Wellness Director, both said no one told them the resident was found on the floor. The Wellness Director said the policy was that if a caregiver found a resident on the floor, they must first call a nurse to assess the resident. The Wellness Director said that if a nurse was unavailable in the facility, the caregiver must call her, and she would tell them what to do next. 2. A record review of resident #15 revealed he required assistance with self-administration of medications.	A 025		

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A 025	Continued From page 8 On at 11:35 AM, observation during a med pass revealed the unlicensed Memory Care Coordinator was providing medication to resident #15. Review of the medication observation record (MORS) and prescription label reflected the dose times for , / , were at 9 AM, 1 PM, and 5 PM starting on . On at 1:13 PM, The unlicensed Memory Care Coordinator stated when resident #15 first moved in the time was 11 AM for his . / , . Further stating, she would let the nurse know of the time change. On at 2:53 PM, the Wellness Director stated she was not aware and would look into the medication time change and look for the physician's order. The facility's Medication, Assistance, Administration Policy states appropriately trained or licensed employees administering or assisting with medications should follow the "7 Rights of Medication Administration: right medication, right dose, right time, right route, right resident, right documentation, and right to refuse. Medication directions on the pharmacy label should correlate with the medication directions on the MORs. Medications should be administered in the correct window of time, that is, 1 hour before or 1 hour after the stated time. Medications are to be given only within the parameters of the physician's orders. Class II	A 025		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders	A 056		

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A 056	Continued From page 9 (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 the resident's health care provider. The new	A 056		

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A 056	Continued From page 10 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., before dispensing any sample or complimentary	A 056		

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A 056	Continued From page 11 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 interview and record review the facility failed to 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 for 1 of 7 sampled residents. (#9) Findings: A review of resident #9's record revealed he was admitted on . His record contained a Resident Health Assessment form (1823) dated . His diagnoses included , , and , . The resident #9 required assistance with self-administration of medication. A review of resident #9's Medication Observation Record (MOR) for and found the following medications were ordered by the Primary Care Provider (PCP): Jardiance 25mg - Take ½ tablet (12.5mg) by daily, 1000mg one tablet by twice daily, and , 100mg one tablet by daily. Further review of resident #9's MOR revealed documentation of Jardiance being "not available" or "not on cart" from through 31, 2025 and continued to be not available from through 12, 2025. was not documented as given from through . , and	A 056		

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A 056	Continued From page 12 continued to be unavailable from through 4, 2025. was not documented as given from through , and continued to be unavailable from through 4, 2025. A review of resident #9's and facility notes did not find any documentation of facility staff notifying the PCP when medications were unavailable. On at 2:50 PM, in an interview with the Wellness Director, she confirmed the findings. She said she would call and find out if the medications had been discontinued by the doctor at the VA. She also said she would call the residents' son who usually brings medications. (Photo Evidence Obtained) 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	A 078		

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A 078	Continued From page 13 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 and the staffing agency or contractor must	A 078		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE LIVING AT HUNTER'S CREEK	1701 BALL PARK RD KISSIMMEE, FL 34741

(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 14 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 observation, record reviews, and interviews, the facility failed to ensure staff (unlicensed Memory Care Coordinator) were qualified to perform their assigned duties consistent with their level of education for a med pass. Findings: On at 11:35 AM, observation revealed during a med pass Unlicensed Memory Care Coordinator spoon fed resident #15 medication after crushing and preparing in applesauce. The Unlicensed Memory Care Coordinator stated, "he does not move his , and we have to feed it to him." A record review of resident #15 revealed a facility admission date of . A 1823 health assessment indicated he required assistance with ambulation, bathing, , toileting, and transferring, the resident was assessed to need assistance with self-administration of medications. Resident #15 had a medical history of communication 's	A 078		

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A 078	Continued From page 15 without dyskinesia and receiving hospice care. On at 11:40 AM, the power of attorney (POA) stated resident #15 has been at the facility a little over one year, is not able to administer his own meds, and has not been able to for years. He explained the staff has always administered his medications since he moved it. In addition, I've offered to do it, but they tell me they must do it. The POA stated she has only done his On at 1:13 PM, Unlicensed Memory Care Coordinator stated she has received training on how to assist with self-administration of medications and confirmed she was a medication technician and not a nurse. She stated resident #15 he used to take his own meds when he moved in. However, now he does not assist at all, won't move his so we have to feed him. On at 2:53 PM, the Wellness Director stated she was not aware of the improper medication pass conducted by Unlicensed Memory Care Coordinator. Unlicensed Memory Care Coordinator and the Wellness Director were made aware that unlicensed staff may not administer medication to the residents. Class III	A 078		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current	A 093		

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

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A 093	Continued From page 17 and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day.	A 093		

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A 093	Continued From page 18 Snacks are not considered to be meals for the purposes of , the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure its menu was reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. Findings: During an interview on at 12:45 PM, review of the facility's current menu revealed they were reviewed and approved by a Dietician on , therefore, the review expired on . The expired menu was used on , , and . The Dietary Manager said she used the expired menu because she did not have a chance to print the	A 093		

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A 093	Continued From page 19 newly approved menu. Class III	A 093		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or	A 161		

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A 161	Continued From page 20 more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ⌄ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure the record for 1 of 8 sampled staff contained a copy of the job description (C). Findings: A record review of Caregiver C revealed a hire date on . There was no documented evidence Caregiver C obtained a job description. On at 11:30 AM, the Business Office Manager provided a blank job description, further stating she overlooked it and it was not signed. (photographic evidence obtained) Class III	A 161		

Agency for Health Care Administration

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