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
	AL11968683	A. BUILDING: _____ B. WING _____	04/27/2026

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BANYAN PLACE BOCA	2950 NW 5TH AVENUE BOCA RATON, FL 33431

(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
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		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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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 interviews and record review, it was determined that the facility failed to ensure that direct care staff completed the required 1-hour (ADRD) training within 30 days of hire for 4 of 4 sampled staff (Staff A, B, C, and D). The findings included: During an interview on at approximately 10:00 AM, the Administrator was asked to provide employee files for Staff A, B, C and D. 1) A review of the personnel file for Staff A (Administrator), hired on , revealed	ZZ875		

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ZZ875	Continued From page 4 that she did not complete the required 1-hour training. 2) A review of the personnel file for Staff B (Director of Nursing), hired on , revealed that she did not complete the required 1-hour training. 3) A review of the personnel file for Staff C (Caregiver), hired on , revealed that he did not complete the required 1-hour training. 4) A review of the personnel file for Staff D (Caregiver), hired on , revealed that she did not complete the required 1-hour training. During an interview on at approximately 3:50 PM, the Administrator was informed that the staff members referenced above did not complete the required one-hour training video from the Department of Elder Affairs (DOEA). The Administrator acknowledged the findings. No additional documentation was provided. Unclassified	ZZ875		

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A 000	Initial Comments An unannounced Relicensure, Complaint (#2025012792, #2025007018 and #2025006082) and Generator Monitoring survey was conducted on at Banyan Place Boca. The facility had deficiencies related to the Relicensure and complaints(2025012792, #2025007018 and #2025006082) at the time of survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or , or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or , . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident,	A 025		

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A 025	Continued From page 1 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 interviews and record reviews, it was determined, the facility failed to respond to calls for assistance and services through the call pendant system from residents in a timely manner. It was also determined that the facility failed to monitor response times to address concerns in a timely manner to ensure appropriate care and services are rendered to all 73 residents residing at the facility(R#1-#73). The findings included:	A 025		

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A 025	Continued From page 2 Confidential interviews conducted with residents and staffs on between the hours 8:00am and 4:00pm revealed multiple concerns regarding staff response times for pendant calls from residents. It was also revealed that residents are not receiving services and/or assistance in a timely manner from staff after the call pendants are rung. Many identified extensive wait times after the pendant was rung. The following concerns were identified: Residents reported delay in response to pendant alerts, , , in the evening or overnight. Multiple Residents reported a 2 hour response time for overnight requests. Residents reported insufficient staffing overnight - specifically in Building A where there is only 1 staff member on the 11:00pm - 7:00am shift. In an interview on at approximately 2:19pm Staff B (Director of Nursing) reported the typical response time to pendant alert to be 30 minutes. Staff B reported the goal response time to be 15 minutes. Staff B reported overnight response time to be 15-20 minutes. Staff B reported it would be surprising if the response time was reported to be longer. In an interview on at approximately 3:15pm Staff B (Director of Nursing) reported the pendant alert is the facility's primary mode of supervision and all residents are provided a pendant. Staff B stated that direct care staff rely on pendant alerts for notification of any non-routine care needs. Staff B reported there was no schedule of rounds to ensure each resident is seen by care staff daily. Staff B reported there was inconsistency in documenting provision of care - sometimes it was added to resident's records and sometimes it wasn't. Staff	A 025		

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A 025	Continued From page 3 B reported there was no specific outline of daily duties for each care staff - they did not have assigned residents to oversee. Care staff were responsible for communicating with other care staff on duty to collaborate on meeting resident needs. A record review of the facility's Pendant Alert Response Protocol revealed the following: Objective: Ensure timely and appropriate response to resident pendant alerts to maintain safety and provide high-quality care. Response Time Expectation: All pendant alerts should be responded to within 15 minutes or less. During high-volume times (mealtimes, shift change at 7:00AM and 7:00PM), response times may be slightly longer. Staff Responsibilities: 1. Upon receiving a pendant alert, staff must prioritize and response as quickly as possible. 3. Each response must be documented accurately in the shift report, noting the time of the alert and the time of resolution through the automated system call log. Communication: Staff should communicate any unusual delays or issues to the supervisor immediately. Resident Supervision: Resident supervision includes: Regularly scheduled wellness checks. A record review conducted on a sampled weekday of the pendant alert log documented the following response times exceeding 30 minutes: Date of pendant call Pendant call time Pendant response time 3:33:59AM	A 025		

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A 025	Continued From page 4	A 025		

5:33:51 (5 hours, 33 minutes)
5:14:42AM 3:36:40 (3 hours, 36 minutes)
6:03:47AM 3:04:03 (3 hours, 4 minutes)
6:28: 12AM 49:49 (49 minutes)
9:24:56AM 42:09 (42 minutes)
11:21:23AM 1:28:21 (1 hour, 28 minutes)
12:08:16PM 1:15:35 (1 hour, 15 minutes)
3:02:32PM 1:09:46 (1 hour, 9 minutes)
3:29:36PM 3:29:41 (3 hours, 29 minutes)
3:36:23PM 3:22:54 (3 hours 22 minutes)
4:03:33PM 2:55:44 (2 hours, 55 minutes)
5:06:35PM 59:07 (59 minutes)
6:19:28PM 39:49 (39 minutes)
7:08:48PM 2:04:53 (2 hours, 4 minutes)
8:18:39PM 1:33:54 (1 hour, 33 minutes)
11:00:52PM 40:19 (40 minutes)

A record review conducted on a sampled weekend day of the pendant alert log documented the following response times exceeding 30 minutes:
Date of pendant call Pendant call time
Pendant response time
1:09:51AM 4:34:29 (4 hours, 34 minutes)
3:57:32AM 2:15:34 (2 hours, 57 minutes)
6:50:22AM 42:50 (42 minutes)

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A 025	Continued From page 5	A 025		

8:20:04AM 46:45 (46 minutes)
9:24:56AM 42:09 (42 minutes)
1:03:52PM 50:21 (50 minutes)
3:55:55PM 31:30 (31 minutes)
5:23:32PM 1:08:03 (1 hour, 8 minutes)
5:23:38PM 2:14:04 (2 hours, 14 minutes)
6:01:58PM 2:16:28 (2 hours 16 minutes)
7:02:08PM 2:47:14 (2 hours, 47 minutes)
7:03:15PM 1:09:40 (1 hour, 9 minutes)
8:48:39PM 4:10:00 (4 hours, 10 minutes)
11:04:54PM 1:38:54 (1 hour, 38 minutes)

A record review of the full pendant alert log for - revealed a total of 7,027 total events and an average response time of 1:00:26. Further review revealed multiple concerns with pendant response times by facility staff. There were multiple instances on a daily basis where the response time was more than 60 minutes. This pattern was consistent across weekdays and weekends. Management staff failed to note this pattern or address this matter to improve the wait times to ensure resident's safety and well-being were addressed and maintained. Facility had no documentation reflecting monitoring, auditing or staff meetings to address the lengthy response times and upon interview were unaware of the pattern.

On at approximately 3:50pm in an exit interview with Staff A (Administrator) and Staff B the extended response time to pendant alerts and

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A 025	Continued From page 6 its impact on resident supervision, care and services was discussed. No additional information or documentation was provided by facility. Class III	A 025		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	A 032		

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A 032	Continued From page 7 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interviews and record review, it was determined that the facility failed to provide documentation of staff participation in elopement drills conducted for 9 out of 9 sampled staff (Staff A, B, C, D, E, F, G, H, and I) Findings included:	A 032		

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A 032	Continued From page 8 During an interview on at 9:23 AM, the Administrator was asked to provide documentation for the facility's elopement drills conducted twice a year for 2024 and 2025. 1) Review of the facility's personnel file for Staff A (Administrator) with hire date of revealed Staff A had no documentation of participating in elopement drills twice a year for 2024 and 2025. 2) Review of the facility's personnel file for Staff B (Director of Nursing) with hire date of revealed Staff B had no documentation of participating in elopement drills twice a year for 2024 and 2025. 3) Review of the facility's personnel file for Staff C (Caregiver) with hire date of revealed Staff C had no documentation of participating in elopement drills twice a year for 2024 and 2025. 4) Review of the facility's personnel file for Staff D (Caregiver/Med-Tech) with hire date of revealed Staff D had no documentation of participating in elopement drills twice a year for 2024 and 2025. 5) Review of the facility's personnel file for Staff E (Caregiver) with hire date of revealed Staff E had no documentation of participating in elopement drills twice a year for 2024 and 2025. 6) Review of the facility's personnel file for Staff F (Caregiver) with hire date of revealed Staff F had no documentation of participating in elopement drills twice a year for 2024 and 2025.	A 032		

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A 032	Continued From page 9 7) Review of the facility's personnel file for Staff G (Med-Tech/Caregiver) with hire date of revealed Staff G had no documentation of participating in elopement drills twice a year for 2024 and 2025. 8) Review of the facility's personnel file for Staff H (Licensed Practical Nurse) with hire date of revealed Staff H had no documentation of participating in elopement drills twice a year for 2024 and 2025. 9) Review of the facility's personnel file for Staff I (Med-Tech/Caregiver) with hire date of revealed Staff I had no documentation of participating in elopement drills twice a year for 2024 and 2025. During an interview with the Administrator on at 2:55 PM she was informed that direct care Staff A, B, C, D, E, F, G, H, I, did not participate in elopement drills for 2024 and 2025. The Administrator acknowledged the findings mentioned above. Class III	A 032		
A 075	429.255( ) FS Use of Personnel; Emergency Care ( ) (3)(a) An assisted living facility licensed under this part with 17 or more beds shall have on the premises at all times a functioning automated external defibrillator as defined in s. 768.1325(2)(b). (b) The facility is encouraged to register the location of each automated external defibrillator with a local emergency medical services medical	A 075		

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A 075	Continued From page 10 director. (c) The provisions of ss. 768.13 and 768.1325 apply to automated external defibrillators within the facility. (4) Facility staff may withhold or withdraw , , or the use of an automated external defibrillator if presented with an order not to executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing , , or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing , , or use of an automated external defibrillator as otherwise permitted by law. (5) The agency may adopt rules to implement the provisions of this section relating to use of an automated external defibrillator. This Statute or Rule is not met as evidenced by: Based on record review, interview and observation, it was determined that the facility failed to properly maintain an Automated External Defibrillator ( ) on its premises at all times in working order. The findings included: A review of an informational website, www.nlm.nih.gov revealed the following: Sudden (SCA) is an emergency. A person having SCA needs to be treated with a	A 075		

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A 075	Continued From page 11 defibrillator right away. A defibrillator is a device sends an electric to the . The electric can restore a normal rhythm to a that's stopped beating. To work well, it needs to be done within minutes of the SCA. During an interview on at approximately 11:25 AM, the Administrator was asked to provide the location of the facility's device(s). At that time, she stated that she was not aware of the location. The Administrator was then asked who was responsible for overseeing maintenance of the device to ensure that all components were not expired. She stated that she was unsure and would contact the facility's maintenance director to confirm whether he was responsible for overseeing the maintenance of the device. During an interview on at approximately 11:35 AM, Staff B (Director of Nursing) was asked to provide the location of the facility's device(s). At that time, she stated that she was not aware of the location. During an interview on at 11:43 AM, Staff F (Caregiver) was asked if he was aware of the location of the facility's device(s) in building A and B. Staff F stated that he was not aware that the facility had an device. During an interview on at 11:46 AM, Staff D (Caregiver/Medication Technician) was asked if she was aware of the location of the facility's device(s) in building A and B. Staff D stated that she was not aware that the facility had an device for staff use. During an interview on at 11:51 AM, Staff G (Caregiver/Medication Technician) was	A 075		

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A 075	Continued From page 12 asked if she was aware of the location of the facility's device(s) in building A and B. Staff G stated that she was not aware that the facility had an device for staff use. During an interview on at 3:00 PM, Staff H (Facility Nurse) was asked if she was aware of the location of the facility's device(s) in Buildings A and B. Staff H stated that the device is located on the second floor in a closet in building A. Staff H was asked to open the case and showed the surveyor that the was able to turn on. However, the case contained expired pads. She was asked if she was aware of the expired pads, and she stated that she was not. She was then asked who oversees maintenance of the device in Building A, and she stated that she believed it was the maintenance director. After approximately four hours of surveyors interviewing direct care staff members (Administrator, Facility Nurses, Caregivers, and Medication Technicians), the surveyors were able to determine the number and location of the devices in both buildings. A review of an informational website www.mayoclinic.org revealed the following: Store your in a place that's easy to get to. Keep the working properly. Install new batteries as needed, typically every four years. Replace electrode pads as needed. Have spare pads on . Follow the manufacturer's instructions. During an interview on at approximately 3:50 PM, the Administrator was informed of the concerns referenced above. She	A 075		

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A 075	Continued From page 13 acknowledged the findings. Class III	A 075		
A 084	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered	A 084		

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A 084	Continued From page 14 nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and , that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the	A 084		

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A 084	Continued From page 15 levels; l. Apply and remove stockings and hosiery; m. Placement and removal of , bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , , , rate, temperature, and , rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training, must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training	A 084		

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A 084	Continued From page 16 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure unlicensed staff who provided assistance with self-administered medications had successfully completed the 2-hour annual update of medication training requirement for 1 of 2 sampled staff (Staff C). The findings included: During an interview on at approximately 10:00 AM, the Administrator was asked to provide employee file for Staff C (Caregiver / Medication Technician). During an interview on at approximately 12:30 PM, Staff B (Director of Nursing) confirmed that Staff C provided assistance with self-administered medications. A review of the facility's personnel file for Staff C, hired on , revealed that he completed an initial 6-hour training on . However, no other documentation was provided indicating that he had completed the required 2-hour annual medication training update. During an interview on at approximately 3:50 PM, the Administrator was informed that unlicensed staff (Staff C) was providing assistance with self-administered medications without the required 2-hour annual medication training. She acknowledged the findings. No additional documentation was provided. Class III	A 084		

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A 078	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. 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	A 078		

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A 078	Continued From page 18 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 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 interview and record review, it was determined that the facility failed to ensure 2 of 4 sampled staff (Staff B and C) had provided within 30 days of hire, a written statement from a health care provider documenting that this individual did not have any signs or symptoms of communicable ( ). The facility failed to ensure 4 of 4 sampled staff (Staff A, B, C and D) had provided evidence of a negative ( ) examination on an annual basis. The findings included:	A 078		

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A 078	Continued From page 19 During an interview on at approximately 10:00 AM, the Administrator was asked to provide employee files for Staff A, B, C and D. 1) A review of the personnel file for Staff A (Administrator), hired on , revealed that her last negative exam was completed on . 2) A review of the personnel file for Staff B (Director of Nursing), hired on , revealed that she did not have a one-time written statement from a health care provider documenting that she was free from any signs and symptoms of communicable within 30 days of her hire date or at any time thereafter. Her last negative exam was completed on . 3) A review of the personnel file for Staff C (Caregiver), hired on , revealed that he did not have a one-time written statement from a health care provider documenting that she was free from any signs and symptoms of communicable within 30 days of her hire date or at any time thereafter. Her last negative exam was completed on . 4) A review of the personnel file for Staff D (Caregiver), hired on , revealed that her last negative exam was completed on . During an interview on at approximately 3:50 PM, the Administrator was informed of the missing documentation, including the one-time written statement regarding communicable status and a current	A 078		

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A 078	Continued From page 20 negative exam for the staff members mentioned above. The Administrator acknowledged the findings. No additional documentation was provided. Class III	A 078		