

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R																						
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210																								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE																						
(A 000)	Initial Comments A second follow up to an Extended Congregate Care survey was conducted on 2012. Bayview Retirement Center had 3 uncorrected deficiencies and 3 new deficiencies found at the time of the visit.	(A 000)																								
A 079	58A-5.019(4) FAC Staffing Standards - Levels (4) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities shall maintain the following minimum staff hours per week: <table border="0"> <tr> <td>Number of Residents</td> <td>Staff Hours/Week</td> </tr> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td>6-15</td> <td>212</td> </tr> <tr> <td>16-25</td> <td>253</td> </tr> <tr> <td>26-35</td> <td>294</td> </tr> <tr> <td>36-45</td> <td>335</td> </tr> <tr> <td>46-55</td> <td>375</td> </tr> <tr> <td>56-65</td> <td>416</td> </tr> <tr> <td>66-75</td> <td>457</td> </tr> <tr> <td>76-85</td> <td>498</td> </tr> <tr> <td>86-95</td> <td>539</td> </tr> </table> For every 20 residents over 95 add 42 staff hours per week. 2. At least one staff member who has access to facility and resident records in case of an emergency shall be within the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 3. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night. 4. At least one staff member who is trained in First Aid and _____ as provided under Rule 58A-5.0191, F.A.C., shall be within the facility at	Number of Residents	Staff Hours/Week	0-5	168	6-15	212	16-25	253	26-35	294	36-45	335	46-55	375	56-65	416	66-75	457	76-85	498	86-95	539	A 079		
Number of Residents	Staff Hours/Week																									
0-5	168																									
6-15	212																									
16-25	253																									
26-35	294																									
36-45	335																									
46-55	375																									
56-65	416																									
66-75	457																									
76-85	498																									
86-95	539																									

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0000

Q50C13

If continuation sheet 1 of 20

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 079	Continued From page 1 all times when residents are in the facility. 5. During periods of temporary absence of the administrator or manager when residents are on the premises, a staff member who is at least _____ must be designated in writing to be in charge of the facility. 6. Staff whose duties are exclusively building maintenance, clerical, or food preparation shall not be counted toward meeting the minimum staffing hours requirement. 7. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours provided the administrator is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 8. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, shall have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents scheduled and unscheduled service needs, resident contracts, and resident care standards as described in Rule 58A-5.0182, F.A.C. (c) The facility must maintain a written work schedule which reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules for direct care staff available to residents or representatives, specific to the resident's care. (d) The facility shall be required to provide staff immediately when the Agency determines that the requirements of paragraph (a) are not met. The	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 079	Continued From page 2 facility shall also be required to immediately increase staff above the minimum levels established in paragraph (a) if the Agency determines that adequate supervision and care are not being provided to residents, resident care standards described in Rule 58A-5.0182, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The Agency shall consult with the facility administrator and residents regarding any determination that additional staff is required. 1. When additional staff is required above the minimum, the agency shall require the submission, within the time specified in the notification, of a corrective action plan indicating how the increased staffing is to be achieved and resident service needs will be met. The plan shall be reviewed by the agency to determine if the plan will increase the staff to needed levels and meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, modifications may be made in staffing requirements for the facility and the facility shall no longer be required to maintain a plan with the agency. 3. Based on the recommendations of the local fire safety authority, the Agency may require additional staff when the facility fails to meet the fire safety standards described in Section 429.41, F.S., and Rule Chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the Agency that fire safety requirements are being met. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios.	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 079	Continued From page 3 (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of Rule 58A-5.029, 58A-5.030, or 58A-5.031, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on facility record review and an interview with the manager and staff, the facility failed to maintain the minimum staffing requirement of 212 hours for a facility with 14 residents. The findings include: A review of facility staffing revealed: Employee #1 worked 32 hours per week. Employee #2 worked 48 hours per week. Employee #3 worked 48 hours per week. Employee #4 worked 36 hours per week. Employee #5 worked 45 hours per week. Employee #6 did not work at the facility. It was noted that employee #3 was one of the owners of the facility. Of the 48 hours worked at or for the facility, direct care to the residents was less than 25% of 48 hours worked. The raw total of hours was a total of 209 hours per week. Based on interviews with staff on 2012 at 10:30 am revealed that employee #3 rarely worked the scheduled 48 hours and that less than 25% of that time involved direct care. They also confirmed that the facility manager was correct, that employee #6 was never at the facility. Using a full 25% of 48 hours for employee #3 as direct care hours left 173 hours of direct care hours available to meet the needs of the	A 079			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 079	Continued From page 4 residents. This was confirmed in an interview with the manager at 1:30 pm on _____, 2012. Class III	A 079			
{A 080}	58A-5.0191(1) FAC Training - Core & Competency Test Staff Training Requirements and Competency Test. (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to Section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to _____, 1997, and managers who attended the core training program prior to _____, 1998, shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with Part II of Chapter 468, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years as provided under Section 429.52, F.S.	{A 080}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 080}	Continued From page 5 (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed \$200. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on employee record review and an interview with the manager, the facility failed to have an administrator who had completed at least 12 hours of continuing education during the last two years and had not had a manager who met the requirements to act in the administrator's behalf for the last two years. The findings include: A review of Employee #1's (administrator) records revealed that the employee had not completed twelve hours of continuing education during the last two years. The last documented training in the records was _____ of 2009. At the time of the survey the facility did not have a	{A 080}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 080}	Continued From page 6 currently qualified administrator who had completed twelve hours of continuing education. This was confirmed in an interview with the manager on _____, 2012 at 12:30 pm. The manager stated that she did not have documentation to show that the administrator had completed the twelve hours of continuing education. The administrator was managing two facilities (Bayview Retirement and Ingleside ALF during the last two years until _____ of 2012 when Ingleside Retirement closed. This was previously cited on _____, 2012 and _____, 2012. Class III	{A 080}			
A 081	58A-5.0191(2) FAC Training - Staff In-Service (2) 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. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 081	Continued From page 7 training within 30 days of employment that covers the following subjects: 1. Reporting major incidents. 2. Reporting adverse incidents. 3. 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 (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility 's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility 's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 081	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on employee record review and an interview with the manager, the facility failed to ensure that two of six direct care staff (Employees #2 and #5) received a minimum of one hour of training in: _____ control, facility sanitation procedures, reporting major incidents, safe food handling, emergency evacuation, resident rights, reporting _____, neglect, and _____. The facility failed to provide 3 hours of training in: resident behavior and needs, and activities of daily living. They also failed to provide training in the facility's elopement response policies and procedures. The findings include: A review of personnel records revealed that Employee #2, hired _____, 2012, did not have documentation of completed training in: assisting with activities of daily living, _____ control, emergency and evacuation procedures, facility sanitation procedures, reporting major incidents, safe food handling, resident rights, reporting _____ and neglect, resident behaviors, elopement response and procedures. A review of personnel records revealed that Employee #5 did not have documentation of any completed trainings since beginning work at the facility in _____, 2012. This was confirmed in an interview with the manager on _____, 2012, at 1:30 pm. Class III	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 083)	58A-5.0191(4) FAC Training - First Aid and (4) FIRST AID AND A staff member who has completed courses in First Aid and _____ and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation of attendance at First Aid or _____ course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American _____ Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and _____ This Statute or Rule is not met as evidenced by: Based on facility record review and an interview with the manager, the facility failed to ensure that there was at least one employee with _____/First Aid was on duty twenty four hours a day for four of six employees reviewed (#2, #4, #5, and #6). The findings include: A review of personnel records for Employee #2, hired _____ 2012 revealed that _____/First Aid training expired in _____ of 2011. A review of personnel records revealed that Employee #4, hired _____ 2010 and Employee #5, hired _____ 2012 did not have any documentation of _____/First Aid training	(A 083)			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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 083}	Continued From page 10 A review of personnel records revealed that Employee #6 had First Aid training that expired in 2012. This was confirmed in an interview with the manager on 2012 at 1:00 pm. Class III	{A 083}		
{AE210}	58A-5.0191(7) FAC ECC - Training Staff Training Requirements and Competency Test. (7) EXTENDED CONGREGATE CARE TRAINING. (a) The administrator and extended congregate care supervisor, if different from the administrator, must complete core training and 4 hours of initial training in extended congregate care prior to the facility's receiving its extended congregate care license or within 3 months of beginning employment in the facility as an administrator or ECC supervisor. Successful completion of the assisted living facility core training shall be a prerequisite for this training. ECC supervisors who attended the assisted living facility core training prior to 1998, shall not be required to take the assisted living facility core training competency test. (b) The administrator and the extended congregate care supervisor, if different from the administrator, must complete a minimum of 4 hours of continuing education every two years in topics relating to the physical, , or social needs of frail elderly and persons, or persons with or related (c) All direct care staff providing care to residents in an extended congregate care program must	{AE210}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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
{AE210}	Continued From page 11 complete at least 2 hours of in-service training, provided by the facility administrator or ECC supervisor, within 6 months of beginning employment in the facility. The training must address extended congregate care concepts and requirements, including statutory and rule requirements, and delivery of personal care and supportive services in an extended congregate care facility. This Statute or Rule is not met as evidenced by: Based on employee record review and an interview with the manager, the facility failed to ensure that the administrator had completed four hours of continuing education in related topics regarding the care of the elderly, or persons or persons with for one of six employees reviewed (#6). The findings include: A review of Employee #6's (the administrator and extended congregate care supervisor) personnel record revealed that the employee had not completed four hours of continuing education in topics related to residents being cared for in an extended congregate care facility. This was confirmed in an interview with the manager on 2012 at 1:00 pm. The manager stated that the training had not been completed. This was previously cited on 2012 and	{AE210}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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
{AE210}	Continued From page 12 on , 2012. Class III	{AE210}		
AZ815	408.809, 435.02(2), 435.06 Background Screening; Prohibited Offenses 408.809, F.S. (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest if the agency has reason to believe that such person has been convicted of any offense prohibited by s. 435.04. For each controlling interest who has been convicted of any such offense, the licensee shall submit to the agency a description and explanation of the conviction at the time of license application. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, contracting with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients. Evidence of contractor	AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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
AZ815	Continued From page 13 screening may be retained by the contractor ' s employer or the licensee. (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person ' s fingerprints to the Federal Bureau of Investigation for a national criminal history record check. If the fingerprints of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g), the person must file a complete set of fingerprints with the agency and the agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The fingerprints may be retained by the Department of Law Enforcement under s. 943.05(2)(g). The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person fingerprinted. Proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the agency, the Department of Health, the Agency for Persons with , the Department of Children and Family Services, or the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651 satisfies the	AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210			
(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)	(X6) COMPLETE DATE	
AZ815	Continued From page 14 requirements of this section if the person subject to screening has not been unemployed for more than 90 days and such proof is accompanied, under penalty of perjury, by an affidavit of compliance with the provisions of chapter 435 and this section using forms provided by the agency. (3) All fingerprints must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony. (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence.	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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
AZ815	Continued From page 15 (f) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (g) Section 817.234, relating to false and fraudulent insurance claims. (h) Section 817.505, relating to patient brokering. (i) Section 817.568, relating to criminal use of personal identification information. (j) Section 817.60, relating to obtaining a credit card through fraudulent means. (k) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (l) Section 831.01, relating to forgery. (m) Section 831.02, relating to uttering forged instruments. (n) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (o) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (p) Section 831.30, relating to fraud in obtaining medicinal drugs. (q) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. A person who serves as a controlling interest of, is employed by, or contracts with a licensee on 2010, who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by 31, 2015. The agency may adopt rules to establish a schedule to stagger the implementation of the required rescreening over the 5-year period, beginning , 2010, through , 2015. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense	AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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
AZ815	Continued From page 16 and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: - Does not have an active professional license or certification from the Department of Health; or - Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice.	AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210		
(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
AZ815	Continued From page 17 (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining fingerprints pursuant to s. 943.05(2). (8) There is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06, F.S. (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any _____ person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of	AZ815		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210			
(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	
AZ815	Continued From page 18 employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including fingerprints if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no unemployment compensation or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the	AZ815			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963833	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER BAYVIEW RETIREMENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210			
(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	
AZ815	Continued From page 19 report was issued or who was regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02(2), F.S. "Employee " means any person required by law to be screened pursuant to this chapter. This Statute or Rule is not met as evidenced by: Based on employee record review and an interview with the manager, the facility failed to ensure that a level two background screening was completed on one of six employees (#5). The findings include: A review of the personnel record for employee #5, hired ... 2012, revealed that no background screening was completed on this employee. The employee had been working on a full time basis for over 30 days. An interview with the manager on 2012 at 1:30 pm confirmed that a background screening was not completed prior to the administrator allowing the employee to begin working in the facility. Unclassified	AZ815			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11963833	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
Name of Facility BAYVIEW RETIREMENT CENTER	Street Address, City, State, Zip Code 2200 BAYVIEW AVENUE JACKSONVILLE, FL 32210	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0084</u> Reg. # <u>58A-5.0191(5) FAC</u> LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>KW</u>	Reviewed By <u>KW</u>	Date: <u>1/9/13</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>1/9/13</u>
State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
CMS RO				

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Bayview Retirement Center
2200 Bayview Avenue
Jacksonville, FL 32210

Dear Administrator:

This letter reports the findings of a revisit survey conducted on _____, 2012 by representatives of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the uncorrected deficiencies, identified during the revisit.

All deficiencies should have been corrected no later than _____, 2012. Due to your continued non-compliance, a recommendation to deny renewal of your license has been forwarded to the Central Office in Tallahassee. This action, if taken, will be a matter of separate correspondence from the Central Office in Tallahassee.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (904) 798-4201.

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

KW/sm
Enclosure

