STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966874	01/28/2019
NAME OF PROVIDER OR SUPPLIER **SUNNY DAYS ALF, INC II**	STREET ADDRESS, CITY, STATE, ZIP CODE **4645 SW VAHALLA ST** **PORT SAINT LUCIE, FL 34953**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced abbreviated Relicensure survey and Limited Mental Health monitoring survey was conducted on at Sunny Days ALF, Inc. II, License #10988 . The facility had deficiencies at the time of the visit.

0051 - Medication - Pill Organizers - 58A-5.0185(2) FAC

Based on observation, record review and staff interview, the Provider failed to ensure pill organizers were only used or maintained residents who were able to self-administer medications for 2 of 5 residents (Residents #2 and #4).

The findings included:

On at 9:00 AM during observation of assistance with self-administered medications, Staff A removed a pill organizer from a desk drawer containing a labeled pill organizer for Resident #4. This pill organizer contained an 81 mg , and a multi- in sectioned labeled per individual week day. Staff A poured the contents into a small plastic medication cup. She handed the medication cup to the Resident and observed the resident take the pills.

Shortly thereafter, Staff A removed another pill organizer from the desk drawer for Resident #2 that contained the following morning medications, as per medication sheet placed with pill organizer:
1) 20 mg
2) 20 mg
3) L-Thyroxine 112 mcg
4) 5Hydrochlorthia 12.5 mg
5) I-Caps (Lutien & Zeaxanthin for)
6) Asprin 81 mg
7) Nature's Plus & , chewable
8) Nature's Way and D3 ,
Staff A poured the contents of the pill organizer for that date and time into a small plastic medication cup and handed it to Resident #2. This resident was observed taking the medications.

The current Health Assessments for Resident #2 and #4 documented both residents required assistance with their medications.

Interview with the Administrator, whose is a Registered Nurse, conducted on at approximately

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9:30 AM, revealed the pill organizer for Resident #2 is maintained by this Resident's daughter, and the pill organizer for Resident #4 is filled by the Administrator. The Adminstrator stated she was aware pill organizers were not to be used for residents who could not self-administer, but she did not think there was any issue with using it for over-the-counter , and Multi- for Resident #4. She also stated Resident #2's daughter insisted on filling the pill organizer for her mother. The Administrator confirmed that neither of these residents would be able to self-administer their medications.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation, staff interview and resident record review, Staff A failed to properly assist 5 of 5 residents with self-administered medications in accordance with state regulatory procedures outlined in the mandatory annual training for assistance with self-administered medication (Residents #1 - #5).

The findings included:

On beginning at 9:00 AM, Staff A donned disposable gloves without first washing her using proper handwashing techniques.

1) Staff A removed Resident #3's labeled medications from the desk drawer and placed them in small plastic medication cup while at the desk, which was located next to the dining room.
Staff A took the medication cup and handed it to the resident who was sitting at the dining room table and went to the desk to begin to prepare the next resident's medications. The Administrator stated to Staff A, "I am sitting here at the table observing the residents take their medications, but you should watch and make sure they take their medications before walking away."

2) Staff A kept the same disposable gloves on when preparing Resident #4's medications.
Staff A removed Resident #4's medications from a pill organizer located in the desk drawer and placed them in small plastic medication cup.
Staff A handed the medication cup to the Resident who was standing next to the desk.
Staff A observed Resident #4 take the medications.

3) Staff A changed her disposable gloves before preparing Resident #2's medications, but did not wash or sanitize prior to donning gloves.
Staff A removed Resident #2's medications from a pill organizer located in the desk drawer and placed them in small plastic medication cup.

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Staff A handed the medication cup to Resident #2 who was sitting at the Dining Room table.
Staff A observed Resident #2 take the medications.

4) Staff A continued to wear the same disposable gloves and removed Resident #1's labeled medications from the desk drawer and placed them in small plastic medication cup while at the desk.
Staff A took the medication cup and handed it to the resident who was sitting at the dining room table and observed the Resident take the medications.

5) Staff A continued to wear the same disposable gloves and removed Resident #1's labeled medications from the desk drawer and placed them in small plastic medication cup while at the desk.
During the transfer, 3 pills onto the desk. Staff A picked them up with her gloved and put them into the medication cup.
Staff A took the medication cup and handed it to the resident who was sitting at the dining room table and observed the Resident take the medications.

Staff A initialed the MOR when all medications were given.

Staff A did not follow proper procedure for assisting with self-administration of medications by failing to:
a) Ensure proper washing/ sanitizing techniques
b) Taking the medications in its previously dispensed, properly labeled container and bringing it to the resident;
c) In the presence of the resident, reading the label, opening the container, removing the prescribed amount of medication from the container and placing it in another container to provide to the resident.
d) Medications which appear to have been contaminated must not be returned to the container.

The Administrator acknowledged on at 1:30 PM that Staff A did not follow the proper regulatory procedures related to assistance with self-administered medications.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and staff interview, Staff A failed to keep medications for 5 of 5 residents secured/locked at all times (Residents #1-#5) .

The findings included:

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On at 9:00 AM, just prior to Staff A assisting with self-administration of medications, the lock on the desk drawers containing the residents' centrally stored medications was not pushed in, signifying the lock for the drawers had not been engaged.

From 9:30 AM until 1:30 PM, the lock on the medication door had not been engaged, leaving the Residents' medications unsecured.

At 10:00 AM and 1:30 PM, the Administrator observed and acknowledged the desk drawer containing residents' medications being unlocked.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 sampled staff obtained a statement from a health care provider documenting the individual does not have any signs or symptoms of any communicable , (Staff B).

The findings included:

On , during a review of Staff B's personnel file (hire date), no documentation was found showing evidence of a statement from a health care provider documenting that Staff C does not have any signs or symptoms of communicable , ( ).

A request for documentation of health statement was made to the Provider on at approximately 11:30 AM. No further documentation was provided at the time of the survey.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 care staff received the required trainings related to Elopement Response and Safe Food Handling within 30 days of hire (Staff B).

The findings included:

Staff B, a resident care aide, was hired on , and provides direct care assistance, including

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meals, to the residents. During employee record review, there was no documentation found showing completion of the required Elopement Response Training or Safe Food Handling Training within 30 days of hire, or any time thereafter prior to this survey date.

On at 1:30 PM, the Administrator acknowledged the missing documentation for Staff showing completion of the required in-service trainings.

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 care staff received the required training on (/) within 30 days of hire (Staff C).

The findings included:

Staff C, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
During employee record review, there was no documentation found showing completion of the required / Training within 30 days of hire, or any time thereafter prior to this survey date, for this employee.

On at 1:30 PM, the Administrator acknowledged the missing documentation for Staff C showing completion of this required training.

Class III

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on observation, employee record review, and staff interview, the Provider failed to ensure:
1) One (1) of 3 direct care staff had completed an approved course in ( ) [Staff A], and had a currently valid certification card documenting completion of such course; and
2) One (1) of 3 direct care staff had completed a course in Basic First Aid [Staff B]; and held a currently valid card documenting completion of such course.

The findings included:

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On , Staff A was observed working alone at the facility from 8:30 AM until approximately 9:30 AM. There were no other staff scheduled during Staff A's shifts.

On , the personnel record review for Staff A showed Staff A's hire date was . Staff A's personnel record did not contain a currently valid certification card verifying completion of an approved training course.

On , the personnel record review for Staff B showed Staff B's hire date was . Staff B's personnel record did not contain a currently valid First Aid certification card verifying completion of an approved First Aid training course. Staff B is scheduled to work her shifts alone.

On at 1:20 PM, a request for documentation showing completion of First Aid and/or courses for Staff A and Staff B was made to the facility's administrator. No documentation was provided at this time.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on employee record review and staff interview, the Provider failed to ensure:
1) One (1) of 3 unlicensed care staff (Staff A), who provides assistance with the self-administration of medications, received the required 2 hours of annual continued education in assisting with self-administered medications; and
2) Two (2) of 3 unlicensed care staff (Staff A and Staff B) completed the additional 2 hours of training that focuses on the following topics:
a) Assisting residents with syringes that are pre-filled with the proper dosage by a pharmacist and , that are pre-filled by the manufacturer for the resident to self-inject;
b) Assisting with ;
c) Use of a to perform testing; and
d) Assisting residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels;.

The findings included:

1) Staff B, a resident care aide, was hired on . Per interview with the Administrator on at 1:30 PM, it was confirmed that Staff B does assist residents with their medications.

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During employee record review on , there was no documentation for Staff B showing completion of the additional 2 hr state required medication training focusing on the subjects listed above (pre-filled syringes and , for self-injection, , CPAP devices and).

2) Staff A, a resident care aide, was hired on . Per interview with Staff A on at 10:30 AM, she confirmed she provided assistance to residents with self-administered medications, and will assists Resident #1 with dialing her .

During employee record review on , there was no documentation for Staff A showing completion of the state required 2 hour annual continuing education update related to assistance with the self-administration of medications for 2018, and no documentation showing completion of the additional 2 hr state required medication training focusing on the subjects listed above (pre-filled syringes and , for self-injection, , CPAP devices and).

On at 1:20 PM, the Administrator acknowledged the missing documentation which showed completion of the required medication trainings. No further documentation was provided at the time of the survey.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on employee record review and staff interview, the Provider failed to ensure 2 of 3 care staff received the required training in the facility's policy and procedures regarding within 30 days of hire (Staff B and Staff C).

The findings included:

Staff B, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
Staff C, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
During employee record review, there was no documentation found showing completion of the required Training in the facility's policy and procedures within 30 days of hire, or any time thereafter prior to this survey date, for these 2 employees.

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On at 1:30 PM, the Administrator acknowledged the missing documentation for Staff B and Staff C showing completion of the required training.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and staff interview, the Provider failed to:
1) Ensure the required amount of fuel supply, as required by state statute (48 hours), was stored onsite; and
2) Have appropriately functioning monoxide detectors installed.
3) Notify in writing within 5 business days each resident/representative of the Emergency Power Plan's submission and implementation date.
This has the potential to affect all residents in the event of power failure.

The findings included:

On , a review of the facility's Emergency Power Plan summary and Regulatory Requirements was conducted. The EPP, along with state regulation, requires a facility with a capacity of less than 16 beds store a minimum of 48 hours of fuel compatible with the facility's emergency power source (portable generator), and to have functioning monoxide detectors.

Regulation also specifies that within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative of the submission of the EPP to the local emergency management agency for review and approval, and the date of the final implementation the plan. The facility must also maintain a copy of each notification.

On at 1:20 PM, the Administrator confirmed she did not have the required 48 hours of fuel stored onsite. The Administrator stated she was waiting on an estimate and permit for installation of a larger generator that would power the entire facility (2000 sq ft).
The Administrator also stated she did not have functioning monoxide detectors installed, as she was in the process of replacing her smoke detectors with ones that also contained monoxide detectors.
The Administrator confirmed she had not provided written notifications to each resident/representative of the submission or implementation of the EPP, but had notified the residents verbally.

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Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(9) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 direct care staff of a licensed Limited Mental Health (LMH) facility received the required 6 hours of Limited Mental Health training within 6 months of employment (Staff C).

The findings included:

Staff C, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
During employee record review, there was no documentation found showing completion of the required LMH Training for Staff C within 6 months of hire (due to be completed by).

On at 1:30 PM, the Administrator failed to provide the requested documentation showing compliance at the time of this survey.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on facility record review and staff interview, the Provider failed to maintain the employment status of all employees within the Agency for Health Care's Background Screening Clearinghouse (Staff C).

The findings included:

On , a review of the personnel record for Staff C showed Staff C had been employed at the facility since . On at 1:00 PM, the Administrator confirmed Staff C was currently employed at the facility.
On at approximately 1:15 PM, Staff C confirmed she currently worked for the facility. During review of the Provider's employee roster located on the Agency's Background Screening Clearinghouse website, no employment information was found for Staff C on the facility's roster.

On at 1:30 PM, the Administrator acknowledged Staff C was not on the facility's employee roster within the Clearinghouse.

Unclassified

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on facility record review and staff interview, the Provider failed to ensure 1 of 3 employees whose responsibilities required her to provide personal care and/or services directly to residents and have access to the residents' personal property and living areas, was shown to be eligible for employment after completion of a Level 2 Background Screening (Staff C).

The findings included:

1) Staff C is a Resident Care Aide employed by the facility to provide personal care to its residents, and who has access to all of the residents' personal property and living areas, thereby requiring a Level 2 Background Screening (BGS).

While reviewing Staff C's employment record on , it is noted that Staff C's date of hire was .
No copy of an eligible Level 2 BGS printout was found within the employee's file at the time of record review.
A review of Staff C's Level 2 BGS result, located on the Agency's Background Screening website, showed Staff C had received a Level 2 screening on and was completed on with the result being "not eligible" for employment.

On at approximately 1:15 PM, the Administrator stated that Employee C was charged with an offense many years ago for which she was not responsible for, and Staff C had been in the process of trying to get it cleared from her record.
On at approximately 1:15 PM, Staff C stated, via telephone interview, she had submitted documentation to get an exemption, but had not received any response as of this date. She stated it had been quite some time since she had submitted the information.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on employee record review and staff interview, the Provider failed to ensure:
1) Two (2) of 3 employees whose responsibilities required them to provide personal care and/or services directly to residents and to have access to the residents' personal property and living areas, was shown to have a break in employment greater than 90 days, thereby requiring a new background screening to

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be initiated (Staff A and Staff B); and
2) 1 of 3 employees completed an Attestation of Compliance with Background Screening Requirements [AHCA Form 3100-0008, ,] upon hire (Staff C).

The findings included:

1a) Staff A is a Resident Care Aide was employed by the facility on to provide personal care to its residents, and who has access to all of the residents' personal property and living areas, thereby requiring a Level 2 Background Screening (BGS).
Per review of the Agency's Background Screening website, the most current BGS was completed for Staff A on .
A review of Staff A's employment application showed a greater than 90 day break in employment between the date of her last Level 2 BGS and the date of hire at this facility.
Interview conducted with Staff A on at 1:15 PM confirmed there was a greater than 90 day break in employment from to .

1b) Staff B is a Resident Care Aide was employed by the facility on to provide personal care to its residents, and who has access to all of the residents' personal property and living areas, thereby requiring a Level 2 Background Screening (BGS).
Per review of the Agency's Background Screening website, the most current BGS was completed for Staff B on .
A review of Staff A's employment application showed a greater than 90 day break in employment between , to , the date of hire at this facility.

On at 1:25 PM, the Administrator acknowledged there had been no new BGS initiated for Staff A or Staff B due to a break in employment greater than 90 days for these employees.

2) On during review of Staff C's employment file, it was noted that Staff C was hired on .
No signed and dated Attestation of Compliance with Background Screening Requirements [AHCA Form 3100-008] could be located within Staff C's employment file. This form must be completed by the employee, and retained by the provider, upon hire to attest that the employee meets the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense.
Staff C is a caregiver who provides care and assistance to the facility's residents, and who has access to the residents' personal belongings and living space; therefore, Staff C is required to have a Level 2

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Background Screening.

During interview with Administrator on . . . . at 1:25 PM, she acknowledged there was no signed Attestation of Compliance for Staff C.

Unclassified

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0000 - Initial Comments

An unannounced abbreviated Relicensure survey and Limited Mental Health monitoring survey was conducted on at Sunny Days ALF, Inc. II, License #10988 . The facility had deficiencies at the time of the visit.

0051 - Medication - Pill Organizers - 58A-5.0185(2) FAC

Based on observation, record review and staff interview, the Provider failed to ensure pill organizers were only used or maintained residents who were able to self-administer medications for 2 of 5 residents (Residents #2 and #4).

The findings included:

On at 9:00 AM during observation of assistance with self-administered medications, Staff A removed a pill organizer from a desk drawer containing a labeled pill organizer for Resident #4. This pill organizer contained an 81 mg , and a multi- in sectioned labeled per individual week day. Staff A poured the contents into a small plastic medication cup. She handed the medication cup to the Resident and observed the resident take the pills.

Shortly thereafter, Staff A removed another pill organizer from the desk drawer for Resident #2 that contained the following morning medications, as per medication sheet placed with pill organizer:
1) 20 mg
2) 20 mg
3) L-Thyroxine 112 mcg
4) 5Hydrochlorthia 12.5 mg
5) I-Caps (Lutien & Zeaxanthin for)
6) Asprin 81 mg
7) Nature's Plus & , chewable
8) Nature's Way and D3 ,
Staff A poured the contents of the pill organizer for that date and time into a small plastic medication cup and handed it to Resident #2. This resident was observed taking the medications.

The current Health Assessments for Resident #2 and #4 documented both residents required assistance with their medications.

Interview with the Administrator, whose is a Registered Nurse, conducted on at approximately

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9:30 AM, revealed the pill organizer for Resident #2 is maintained by this Resident's daughter, and the pill organizer for Resident #4 is filled by the Administrator. The Adminstrator stated she was aware pill organizers were not to be used for residents who could not self-administer, but she did not think there was any issue with using it for over-the-counter , and Multi- for Resident #4. She also stated Resident #2's daughter insisted on filling the pill organizer for her mother. The Administrator confirmed that neither of these residents would be able to self-administer their medications.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation, staff interview and resident record review, Staff A failed to properly assist 5 of 5 residents with self-administered medications in accordance with state regulatory procedures outlined in the mandatory annual training for assistance with self-administered medication (Residents #1 - #5).

The findings included:

On beginning at 9:00 AM, Staff A donned disposable gloves without first washing her using proper handwashing techniques.

1) Staff A removed Resident #3's labeled medications from the desk drawer and placed them in small plastic medication cup while at the desk, which was located next to the dining room.
Staff A took the medication cup and handed it to the resident who was sitting at the dining room table and went to the desk to begin to prepare the next resident's medications. The Administrator stated to Staff A, "I am sitting here at the table observing the residents take their medications, but you should watch and make sure they take their medications before walking away."

2) Staff A kept the same disposable gloves on when preparing Resident #4's medications.
Staff A removed Resident #4's medications from a pill organizer located in the desk drawer and placed them in small plastic medication cup.
Staff A handed the medication cup to the Resident who was standing next to the desk.
Staff A observed Resident #4 take the medications.

3) Staff A changed her disposable gloves before preparing Resident #2's medications, but did not wash or sanitize prior to donning gloves.
Staff A removed Resident #2's medications from a pill organizer located in the desk drawer and placed them in small plastic medication cup.

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Staff A handed the medication cup to Resident #2 who was sitting at the Dining Room table.
Staff A observed Resident #2 take the medications.

4) Staff A continued to wear the same disposable gloves and removed Resident #1's labeled medications from the desk drawer and placed them in small plastic medication cup while at the desk.
Staff A took the medication cup and handed it to the resident who was sitting at the dining room table and observed the Resident take the medications.

5) Staff A continued to wear the same disposable gloves and removed Resident #1's labeled medications from the desk drawer and placed them in small plastic medication cup while at the desk.
During the transfer, 3 pills onto the desk. Staff A picked them up with her gloved and put them into the medication cup.
Staff A took the medication cup and handed it to the resident who was sitting at the dining room table and observed the Resident take the medications.

Staff A initialed the MOR when all medications were given.

Staff A did not follow proper procedure for assisting with self-administration of medications by failing to:
a) Ensure proper washing/ sanitizing techniques
b) Taking the medications in its previously dispensed, properly labeled container and bringing it to the resident;
c) In the presence of the resident, reading the label, opening the container, removing the prescribed amount of medication from the container and placing it in another container to provide to the resident.
d) Medications which appear to have been contaminated must not be returned to the container.

The Administrator acknowledged on at 1:30 PM that Staff A did not follow the proper regulatory procedures related to assistance with self-administered medications.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and staff interview, Staff A failed to keep medications for 5 of 5 residents secured/locked at all times (Residents #1-#5) .

The findings included:

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On at 9:00 AM, just prior to Staff A assisting with self-administration of medications, the lock on the desk drawers containing the residents' centrally stored medications was not pushed in, signifying the lock for the drawers had not been engaged.

From 9:30 AM until 1:30 PM, the lock on the medication door had not been engaged, leaving the Residents' medications unsecured.

At 10:00 AM and 1:30 PM, the Administrator observed and acknowledged the desk drawer containing residents' medications being unlocked.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 sampled staff obtained a statement from a health care provider documenting the individual does not have any signs or symptoms of any communicable , (Staff B).

The findings included:

On , during a review of Staff B's personnel file (hire date), no documentation was found showing evidence of a statement from a health care provider documenting that Staff C does not have any signs or symptoms of communicable , ( ).

A request for documentation of health statement was made to the Provider on at approximately 11:30 AM. No further documentation was provided at the time of the survey.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 care staff received the required trainings related to Elopement Response and Safe Food Handling within 30 days of hire (Staff B).

The findings included:

Staff B, a resident care aide, was hired on , and provides direct care assistance, including

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meals, to the residents. During employee record review, there was no documentation found showing completion of the required Elopement Response Training or Safe Food Handling Training within 30 days of hire, or any time thereafter prior to this survey date.

On at 1:30 PM, the Administrator acknowledged the missing documentation for Staff showing completion of the required in-service trainings.

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 care staff received the required training on (/) within 30 days of hire (Staff C).

The findings included:

Staff C, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
During employee record review, there was no documentation found showing completion of the required / Training within 30 days of hire, or any time thereafter prior to this survey date, for this employee.

On at 1:30 PM, the Administrator acknowledged the missing documentation for Staff C showing completion of this required training.

Class III

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on observation, employee record review, and staff interview, the Provider failed to ensure:
1) One (1) of 3 direct care staff had completed an approved course in ( ) [Staff A], and had a currently valid certification card documenting completion of such course; and
2) One (1) of 3 direct care staff had completed a course in Basic First Aid [Staff B]; and held a currently valid card documenting completion of such course.

The findings included:

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On , Staff A was observed working alone at the facility from 8:30 AM until approximately 9:30 AM. There were no other staff scheduled during Staff A's shifts.

On , the personnel record review for Staff A showed Staff A's hire date was . Staff A's personnel record did not contain a currently valid certification card verifying completion of an approved training course.

On , the personnel record review for Staff B showed Staff B's hire date was . Staff B's personnel record did not contain a currently valid First Aid certification card verifying completion of an approved First Aid training course. Staff B is scheduled to work her shifts alone.

On at 1:20 PM, a request for documentation showing completion of First Aid and/or courses for Staff A and Staff B was made to the facility's administrator. No documentation was provided at this time.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on employee record review and staff interview, the Provider failed to ensure:
1) One (1) of 3 unlicensed care staff (Staff A), who provides assistance with the self-administration of medications, received the required 2 hours of annual continued education in assisting with self-administered medications; and
2) Two (2) of 3 unlicensed care staff (Staff A and Staff B) completed the additional 2 hours of training that focuses on the following topics:
a) Assisting residents with syringes that are pre-filled with the proper dosage by a pharmacist and , that are pre-filled by the manufacturer for the resident to self-inject;
b) Assisting with ;
c) Use of a to perform testing; and
d) Assisting residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels;.

The findings included:

1) Staff B, a resident care aide, was hired on . Per interview with the Administrator on at 1:30 PM, it was confirmed that Staff B does assist residents with their medications.

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During employee record review on , there was no documentation for Staff B showing completion of the additional 2 hr state required medication training focusing on the subjects listed above (pre-filled syringes and , for self-injection, , CPAP devices and).

2) Staff A, a resident care aide, was hired on . Per interview with Staff A on at 10:30 AM, she confirmed she provided assistance to residents with self-administered medications, and will assists Resident #1 with dialing her .

During employee record review on , there was no documentation for Staff A showing completion of the state required 2 hour annual continuing education update related to assistance with the self-administration of medications for 2018, and no documentation showing completion of the additional 2 hr state required medication training focusing on the subjects listed above (pre-filled syringes and , for self-injection, , CPAP devices and).

On at 1:20 PM, the Administrator acknowledged the missing documentation which showed completion of the required medication trainings. No further documentation was provided at the time of the survey.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on employee record review and staff interview, the Provider failed to ensure 2 of 3 care staff received the required training in the facility's policy and procedures regarding within 30 days of hire (Staff B and Staff C).

The findings included:

Staff B, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
Staff C, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
During employee record review, there was no documentation found showing completion of the required Training in the facility's policy and procedures within 30 days of hire, or any time thereafter prior to this survey date, for these 2 employees.

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On at 1:30 PM, the Administrator acknowledged the missing documentation for Staff B and Staff C showing completion of the required training.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and staff interview, the Provider failed to:
1) Ensure the required amount of fuel supply, as required by state statute (48 hours), was stored onsite; and
2) Have appropriately functioning monoxide detectors installed.
3) Notify in writing within 5 business days each resident/representative of the Emergency Power Plan's submission and implementation date.
This has the potential to affect all residents in the event of power failure.

The findings included:

On , a review of the facility's Emergency Power Plan summary and Regulatory Requirements was conducted. The EPP, along with state regulation, requires a facility with a capacity of less than 16 beds store a minimum of 48 hours of fuel compatible with the facility's emergency power source (portable generator), and to have functioning monoxide detectors.

Regulation also specifies that within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative of the submission of the EPP to the local emergency management agency for review and approval, and the date of the final implementation the plan. The facility must also maintain a copy of each notification.

On at 1:20 PM, the Administrator confirmed she did not have the required 48 hours of fuel stored onsite. The Administrator stated she was waiting on an estimate and permit for installation of a larger generator that would power the entire facility (2000 sq ft).
The Administrator also stated she did not have functioning monoxide detectors installed, as she was in the process of replacing her smoke detectors with ones that also contained monoxide detectors.
The Administrator confirmed she had not provided written notifications to each resident/representative of the submission or implementation of the EPP, but had notified the residents verbally.

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Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(9) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 direct care staff of a licensed Limited Mental Health (LMH) facility received the required 6 hours of Limited Mental Health training within 6 months of employment (Staff C).

The findings included:

Staff C, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
During employee record review, there was no documentation found showing completion of the required LMH Training for Staff C within 6 months of hire (due to be completed by).

On at 1:30 PM, the Administrator failed to provide the requested documentation showing compliance at the time of this survey.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on facility record review and staff interview, the Provider failed to maintain the employment status of all employees within the Agency for Health Care's Background Screening Clearinghouse (Staff C).

The findings included:

On , a review of the personnel record for Staff C showed Staff C had been employed at the facility since . On at 1:00 PM, the Administrator confirmed Staff C was currently employed at the facility.
On at approximately 1:15 PM, Staff C confirmed she currently worked for the facility. During review of the Provider's employee roster located on the Agency's Background Screening Clearinghouse website, no employment information was found for Staff C on the facility's roster.

On at 1:30 PM, the Administrator acknowledged Staff C was not on the facility's employee roster within the Clearinghouse.

Unclassified

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on facility record review and staff interview, the Provider failed to ensure 1 of 3 employees whose responsibilities required her to provide personal care and/or services directly to residents and have access to the residents' personal property and living areas, was shown to be eligible for employment after completion of a Level 2 Background Screening (Staff C).

The findings included:

1) Staff C is a Resident Care Aide employed by the facility to provide personal care to its residents, and who has access to all of the residents' personal property and living areas, thereby requiring a Level 2 Background Screening (BGS).

While reviewing Staff C's employment record on , it is noted that Staff C's date of hire was .
No copy of an eligible Level 2 BGS printout was found within the employee's file at the time of record review.
A review of Staff C's Level 2 BGS result, located on the Agency's Background Screening website, showed Staff C had received a Level 2 screening on and was completed on with the result being "not eligible" for employment.

On at approximately 1:15 PM, the Administrator stated that Employee C was charged with an offense many years ago for which she was not responsible for, and Staff C had been in the process of trying to get it cleared from her record.
On at approximately 1:15 PM, Staff C stated, via telephone interview, she had submitted documentation to get an exemption, but had not received any response as of this date. She stated it had been quite some time since she had submitted the information.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on employee record review and staff interview, the Provider failed to ensure:
1) Two (2) of 3 employees whose responsibilities required them to provide personal care and/or services directly to residents and to have access to the residents' personal property and living areas, was shown to have a break in employment greater than 90 days, thereby requiring a new background screening to

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be initiated (Staff A and Staff B); and
2) 1 of 3 employees completed an Attestation of Compliance with Background Screening Requirements [AHCA Form 3100-0008, ,] upon hire (Staff C).

The findings included:

1a) Staff A is a Resident Care Aide was employed by the facility on to provide personal care to its residents, and who has access to all of the residents' personal property and living areas, thereby requiring a Level 2 Background Screening (BGS).
Per review of the Agency's Background Screening website, the most current BGS was completed for Staff A on .
A review of Staff A's employment application showed a greater than 90 day break in employment between the date of her last Level 2 BGS and the date of hire at this facility.
Interview conducted with Staff A on at 1:15 PM confirmed there was a greater than 90 day break in employment from to .

1b) Staff B is a Resident Care Aide was employed by the facility on to provide personal care to its residents, and who has access to all of the residents' personal property and living areas, thereby requiring a Level 2 Background Screening (BGS).
Per review of the Agency's Background Screening website, the most current BGS was completed for Staff B on .
A review of Staff A's employment application showed a greater than 90 day break in employment between , to , the date of hire at this facility.

On at 1:25 PM, the Administrator acknowledged there had been no new BGS initiated for Staff A or Staff B due to a break in employment greater than 90 days for these employees.

2) On during review of Staff C's employment file, it was noted that Staff C was hired on .
No signed and dated Attestation of Compliance with Background Screening Requirements [AHCA Form 3100-008] could be located within Staff C's employment file. This form must be completed by the employee, and retained by the provider, upon hire to attest that the employee meets the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense.
Staff C is a caregiver who provides care and assistance to the facility's residents, and who has access to the residents' personal belongings and living space; therefore, Staff C is required to have a Level 2

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Background Screening.

During interview with Administrator on . . . . at 1:25 PM, she acknowledged there was no signed Attestation of Compliance for Staff C.

Unclassified

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0000 - Initial Comments

An unannounced abbreviated Relicensure survey and Limited Mental Health monitoring survey was conducted on at Sunny Days ALF, Inc. II, License #10988 . The facility had deficiencies at the time of the visit.

0051 - Medication - Pill Organizers - 58A-5.0185(2) FAC

Based on observation, record review and staff interview, the Provider failed to ensure pill organizers were only used or maintained residents who were able to self-administer medications for 2 of 5 residents (Residents #2 and #4).

The findings included:

On at 9:00 AM during observation of assistance with self-administered medications, Staff A removed a pill organizer from a desk drawer containing a labeled pill organizer for Resident #4. This pill organizer contained an 81 mg , and a multi- in sectioned labeled per individual week day. Staff A poured the contents into a small plastic medication cup. She handed the medication cup to the Resident and observed the resident take the pills.

Shortly thereafter, Staff A removed another pill organizer from the desk drawer for Resident #2 that contained the following morning medications, as per medication sheet placed with pill organizer:
1) 20 mg
2) 20 mg
3) L-Thyroxine 112 mcg
4) 5Hydrochlorthia 12.5 mg
5) I-Caps (Lutien & Zeaxanthin for)
6) Asprin 81 mg
7) Nature's Plus & , chewable
8) Nature's Way and D3 ,
Staff A poured the contents of the pill organizer for that date and time into a small plastic medication cup and handed it to Resident #2. This resident was observed taking the medications.

The current Health Assessments for Resident #2 and #4 documented both residents required assistance with their medications.

Interview with the Administrator, whose is a Registered Nurse, conducted on at approximately

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9:30 AM, revealed the pill organizer for Resident #2 is maintained by this Resident's daughter, and the pill organizer for Resident #4 is filled by the Administrator. The Adminstrator stated she was aware pill organizers were not to be used for residents who could not self-administer, but she did not think there was any issue with using it for over-the-counter , and Multi- for Resident #4. She also stated Resident #2's daughter insisted on filling the pill organizer for her mother. The Administrator confirmed that neither of these residents would be able to self-administer their medications.

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation, staff interview and resident record review, Staff A failed to properly assist 5 of 5 residents with self-administered medications in accordance with state regulatory procedures outlined in the mandatory annual training for assistance with self-administered medication (Residents #1 - #5).

The findings included:

On beginning at 9:00 AM, Staff A donned disposable gloves without first washing her using proper handwashing techniques.

1) Staff A removed Resident #3's labeled medications from the desk drawer and placed them in small plastic medication cup while at the desk, which was located next to the dining room.
Staff A took the medication cup and handed it to the resident who was sitting at the dining room table and went to the desk to begin to prepare the next resident's medications. The Administrator stated to Staff A, "I am sitting here at the table observing the residents take their medications, but you should watch and make sure they take their medications before walking away."

2) Staff A kept the same disposable gloves on when preparing Resident #4's medications.
Staff A removed Resident #4's medications from a pill organizer located in the desk drawer and placed them in small plastic medication cup.
Staff A handed the medication cup to the Resident who was standing next to the desk.
Staff A observed Resident #4 take the medications.

3) Staff A changed her disposable gloves before preparing Resident #2's medications, but did not wash or sanitize prior to donning gloves.
Staff A removed Resident #2's medications from a pill organizer located in the desk drawer and placed them in small plastic medication cup.

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Staff A handed the medication cup to Resident #2 who was sitting at the Dining Room table.
Staff A observed Resident #2 take the medications.

4) Staff A continued to wear the same disposable gloves and removed Resident #1's labeled medications from the desk drawer and placed them in small plastic medication cup while at the desk.
Staff A took the medication cup and handed it to the resident who was sitting at the dining room table and observed the Resident take the medications.

5) Staff A continued to wear the same disposable gloves and removed Resident #1's labeled medications from the desk drawer and placed them in small plastic medication cup while at the desk.
During the transfer, 3 pills onto the desk. Staff A picked them up with her gloved and put them into the medication cup.
Staff A took the medication cup and handed it to the resident who was sitting at the dining room table and observed the Resident take the medications.

Staff A initialed the MOR when all medications were given.

Staff A did not follow proper procedure for assisting with self-administration of medications by failing to:
a) Ensure proper washing/ sanitizing techniques
b) Taking the medications in its previously dispensed, properly labeled container and bringing it to the resident;
c) In the presence of the resident, reading the label, opening the container, removing the prescribed amount of medication from the container and placing it in another container to provide to the resident.
d) Medications which appear to have been contaminated must not be returned to the container.

The Administrator acknowledged on at 1:30 PM that Staff A did not follow the proper regulatory procedures related to assistance with self-administered medications.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and staff interview, Staff A failed to keep medications for 5 of 5 residents secured/locked at all times (Residents #1-#5) .

The findings included:

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On at 9:00 AM, just prior to Staff A assisting with self-administration of medications, the lock on the desk drawers containing the residents' centrally stored medications was not pushed in, signifying the lock for the drawers had not been engaged.

From 9:30 AM until 1:30 PM, the lock on the medication door had not been engaged, leaving the Residents' medications unsecured.

At 10:00 AM and 1:30 PM, the Administrator observed and acknowledged the desk drawer containing residents' medications being unlocked.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 sampled staff obtained a statement from a health care provider documenting the individual does not have any signs or symptoms of any communicable , (Staff B).

The findings included:

On , during a review of Staff B's personnel file (hire date), no documentation was found showing evidence of a statement from a health care provider documenting that Staff C does not have any signs or symptoms of communicable , ( ).

A request for documentation of health statement was made to the Provider on at approximately 11:30 AM. No further documentation was provided at the time of the survey.

Class III

0081 - Training - Staff In-Service - 58A-5.0191( ) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 care staff received the required trainings related to Elopement Response and Safe Food Handling within 30 days of hire (Staff B).

The findings included:

Staff B, a resident care aide, was hired on , and provides direct care assistance, including

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meals, to the residents. During employee record review, there was no documentation found showing completion of the required Elopement Response Training or Safe Food Handling Training within 30 days of hire, or any time thereafter prior to this survey date.

On at 1:30 PM, the Administrator acknowledged the missing documentation for Staff showing completion of the required in-service trainings.

Class III

0082 - Training - / - 58A-5.0191(4) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 care staff received the required training on (/) within 30 days of hire (Staff C).

The findings included:

Staff C, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
During employee record review, there was no documentation found showing completion of the required / Training within 30 days of hire, or any time thereafter prior to this survey date, for this employee.

On at 1:30 PM, the Administrator acknowledged the missing documentation for Staff C showing completion of this required training.

Class III

0083 - Training - First Aid and - 58A-5.0191(5) FAC

Based on observation, employee record review, and staff interview, the Provider failed to ensure:
1) One (1) of 3 direct care staff had completed an approved course in ( ) [Staff A], and had a currently valid certification card documenting completion of such course; and
2) One (1) of 3 direct care staff had completed a course in Basic First Aid [Staff B]; and held a currently valid card documenting completion of such course.

The findings included:

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SUNNY DAYS ALF, INC II	**4645 SW VAHALLA ST PORT SAINT LUCIE, FL 34953**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On , Staff A was observed working alone at the facility from 8:30 AM until approximately 9:30 AM. There were no other staff scheduled during Staff A's shifts.

On , the personnel record review for Staff A showed Staff A's hire date was . Staff A's personnel record did not contain a currently valid certification card verifying completion of an approved training course.

On , the personnel record review for Staff B showed Staff B's hire date was . Staff B's personnel record did not contain a currently valid First Aid certification card verifying completion of an approved First Aid training course. Staff B is scheduled to work her shifts alone.

On at 1:20 PM, a request for documentation showing completion of First Aid and/or courses for Staff A and Staff B was made to the facility's administrator. No documentation was provided at this time.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(6) FAC 429.52 (6), FS

Based on employee record review and staff interview, the Provider failed to ensure:
1) One (1) of 3 unlicensed care staff (Staff A), who provides assistance with the self-administration of medications, received the required 2 hours of annual continued education in assisting with self-administered medications; and
2) Two (2) of 3 unlicensed care staff (Staff A and Staff B) completed the additional 2 hours of training that focuses on the following topics:
a) Assisting residents with syringes that are pre-filled with the proper dosage by a pharmacist and , that are pre-filled by the manufacturer for the resident to self-inject;
b) Assisting with ;
c) Use of a to perform testing; and
d) Assisting residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels;.

The findings included:

1) Staff B, a resident care aide, was hired on . Per interview with the Administrator on at 1:30 PM, it was confirmed that Staff B does assist residents with their medications.

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During employee record review on , there was no documentation for Staff B showing completion of the additional 2 hr state required medication training focusing on the subjects listed above (pre-filled syringes and , for self-injection, , CPAP devices and).

2) Staff A, a resident care aide, was hired on . Per interview with Staff A on at 10:30 AM, she confirmed she provided assistance to residents with self-administered medications, and will assists Resident #1 with dialing her .

During employee record review on , there was no documentation for Staff A showing completion of the state required 2 hour annual continuing education update related to assistance with the self-administration of medications for 2018, and no documentation showing completion of the additional 2 hr state required medication training focusing on the subjects listed above (pre-filled syringes and , for self-injection, , CPAP devices and).

On at 1:20 PM, the Administrator acknowledged the missing documentation which showed completion of the required medication trainings. No further documentation was provided at the time of the survey.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on employee record review and staff interview, the Provider failed to ensure 2 of 3 care staff received the required training in the facility's policy and procedures regarding within 30 days of hire (Staff B and Staff C).

The findings included:

Staff B, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
Staff C, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
During employee record review, there was no documentation found showing completion of the required Training in the facility's policy and procedures within 30 days of hire, or any time thereafter prior to this survey date, for these 2 employees.

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On at 1:30 PM, the Administrator acknowledged the missing documentation for Staff B and Staff C showing completion of the required training.

Class III

0200 - Emergency Environmental Control - 58A-5.036 FAC

Based on record review and staff interview, the Provider failed to:
1) Ensure the required amount of fuel supply, as required by state statute (48 hours), was stored onsite; and
2) Have appropriately functioning monoxide detectors installed.
3) Notify in writing within 5 business days each resident/representative of the Emergency Power Plan's submission and implementation date.
This has the potential to affect all residents in the event of power failure.

The findings included:

On , a review of the facility's Emergency Power Plan summary and Regulatory Requirements was conducted. The EPP, along with state regulation, requires a facility with a capacity of less than 16 beds store a minimum of 48 hours of fuel compatible with the facility's emergency power source (portable generator), and to have functioning monoxide detectors.

Regulation also specifies that within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative of the submission of the EPP to the local emergency management agency for review and approval, and the date of the final implementation the plan. The facility must also maintain a copy of each notification.

On at 1:20 PM, the Administrator confirmed she did not have the required 48 hours of fuel stored onsite. The Administrator stated she was waiting on an estimate and permit for installation of a larger generator that would power the entire facility (2000 sq ft).
The Administrator also stated she did not have functioning monoxide detectors installed, as she was in the process of replacing her smoke detectors with ones that also contained monoxide detectors.
The Administrator confirmed she had not provided written notifications to each resident/representative of the submission or implementation of the EPP, but had notified the residents verbally.

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Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(9) FAC

Based on employee record review and staff interview, the Provider failed to ensure 1 of 3 direct care staff of a licensed Limited Mental Health (LMH) facility received the required 6 hours of Limited Mental Health training within 6 months of employment (Staff C).

The findings included:

Staff C, a resident care aide, was hired on , and provides direct care assistance to the facility's residents.
During employee record review, there was no documentation found showing completion of the required LMH Training for Staff C within 6 months of hire (due to be completed by).

On at 1:30 PM, the Administrator failed to provide the requested documentation showing compliance at the time of this survey.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on facility record review and staff interview, the Provider failed to maintain the employment status of all employees within the Agency for Health Care's Background Screening Clearinghouse (Staff C).

The findings included:

On , a review of the personnel record for Staff C showed Staff C had been employed at the facility since . On at 1:00 PM, the Administrator confirmed Staff C was currently employed at the facility.
On at approximately 1:15 PM, Staff C confirmed she currently worked for the facility. During review of the Provider's employee roster located on the Agency's Background Screening Clearinghouse website, no employment information was found for Staff C on the facility's roster.

On at 1:30 PM, the Administrator acknowledged Staff C was not on the facility's employee roster within the Clearinghouse.

Unclassified

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Z815 - Background Screening; Prohibited Offenses - 408.809; 435.02(2); 435.06 FS

Based on facility record review and staff interview, the Provider failed to ensure 1 of 3 employees whose responsibilities required her to provide personal care and/or services directly to residents and have access to the residents' personal property and living areas, was shown to be eligible for employment after completion of a Level 2 Background Screening (Staff C).

The findings included:

1) Staff C is a Resident Care Aide employed by the facility to provide personal care to its residents, and who has access to all of the residents' personal property and living areas, thereby requiring a Level 2 Background Screening (BGS).

While reviewing Staff C's employment record on , it is noted that Staff C's date of hire was .
No copy of an eligible Level 2 BGS printout was found within the employee's file at the time of record review.
A review of Staff C's Level 2 BGS result, located on the Agency's Background Screening website, showed Staff C had received a Level 2 screening on and was completed on with the result being "not eligible" for employment.

On at approximately 1:15 PM, the Administrator stated that Employee C was charged with an offense many years ago for which she was not responsible for, and Staff C had been in the process of trying to get it cleared from her record.
On at approximately 1:15 PM, Staff C stated, via telephone interview, she had submitted documentation to get an exemption, but had not received any response as of this date. She stated it had been quite some time since she had submitted the information.

Unclassified

Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c); 59A-35.090(2)(d)-(3)

Based on employee record review and staff interview, the Provider failed to ensure:
1) Two (2) of 3 employees whose responsibilities required them to provide personal care and/or services directly to residents and to have access to the residents' personal property and living areas, was shown to have a break in employment greater than 90 days, thereby requiring a new background screening to

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be initiated (Staff A and Staff B); and
2) 1 of 3 employees completed an Attestation of Compliance with Background Screening Requirements [AHCA Form 3100-0008, ,] upon hire (Staff C).

The findings included:

1a) Staff A is a Resident Care Aide was employed by the facility on to provide personal care to its residents, and who has access to all of the residents' personal property and living areas, thereby requiring a Level 2 Background Screening (BGS).
Per review of the Agency's Background Screening website, the most current BGS was completed for Staff A on .
A review of Staff A's employment application showed a greater than 90 day break in employment between the date of her last Level 2 BGS and the date of hire at this facility.
Interview conducted with Staff A on at 1:15 PM confirmed there was a greater than 90 day break in employment from to .

1b) Staff B is a Resident Care Aide was employed by the facility on to provide personal care to its residents, and who has access to all of the residents' personal property and living areas, thereby requiring a Level 2 Background Screening (BGS).
Per review of the Agency's Background Screening website, the most current BGS was completed for Staff B on .
A review of Staff A's employment application showed a greater than 90 day break in employment between , to , the date of hire at this facility.

On at 1:25 PM, the Administrator acknowledged there had been no new BGS initiated for Staff A or Staff B due to a break in employment greater than 90 days for these employees.

2) On during review of Staff C's employment file, it was noted that Staff C was hired on .
No signed and dated Attestation of Compliance with Background Screening Requirements [AHCA Form 3100-008] could be located within Staff C's employment file. This form must be completed by the employee, and retained by the provider, upon hire to attest that the employee meets the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense.
Staff C is a caregiver who provides care and assistance to the facility's residents, and who has access to the residents' personal belongings and living space; therefore, Staff C is required to have a Level 2

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Background Screening.

During interview with Administrator on . . . . at 1:25 PM, she acknowledged there was no signed Attestation of Compliance for Staff C.

Unclassified