Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910926	A. BUILDING: _____ B. WING _____	08/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSA I, INC	182 WEST 9 STREET HIALEAH, FL 33010

(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 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c),	A 161		

AHCA Form 3020-0001

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

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A 161	Continued From page 1 F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity [redacted] to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a completed employment application including references for one out of twenty-one sampled staff (Staff B). Findings included: Personnel records review for Staff B showed the employment application signed on [redacted] had no references. Staff B was interviewed and hired on [redacted]. On [redacted] at 12:30 PM, Administrator acknowledged that Staff B's employment application had no personal references. Class III	A 161		
A 000	Initial Comments A complaint investigation (complaint number 2020010971), COVID-19 control and	A 000		

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A 000	Continued From page 2 generator survey was conducted at Villa Rosa I, Inc. on , through . Deficiencies were identifed at the time of survey.	A 000		
A 030 SS=G	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of	A 030		

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A 030	Continued From page 3 its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the	A 030		

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A 030	Continued From page 4 resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's	A 030		

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A 030	Continued From page 5	A 030		

representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , ,
for health care services, the provision of or arrangement of transportation to health care
. , , ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally . . , ... , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an

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A 030	Continued From page 6 individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without . . . . , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder	A 030		

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A 030	Continued From page 7 . . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . . . or . . . . . under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations, record review and interview the facility failed to honor resident rights to live in a safe environment free of from . . . and neglect and to be treated with consideration and respect. The facility failed to investigate allegations of resident-to-resident . . for three out 33 residents (Residents #1, #2 and #3). Resident #1 reported being raped by another resident, and Residents' #2 and #3 reported being . . . . . , harassed by another resident. The facility also failed to institute adequate precautions to prevent further incidences. The facility failed to properly screen state agency	A 030		

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A 030	Continued From page 8 representatives for COVID-19 prior to their entering the facility. Findings included: 1) On [redacted] at 1:38 PM, a telephone interview was conducted with Resident #1's father. The father reported "my son was raped at the facility, and I am not sure how much I can tell you because it is in litigation with my lawyer." Review of Resident #1 Health Assessment dated [redacted] showed diagnoses of [redacted] with [redacted], and major [redacted]. Further review revealed that resident was alert, aware and oriented X 3, and was independent with ambulation, eating, toileting, and transferring. He required supervision with bathing and [redacted] and assistance with self-care. Review of the adverse incident database showed no report was filed by the facility for Resident #1 concerning the alleged [redacted] and hospitalization. On [redacted] at 9:15AM, the Administrator stated, that on [redacted] she learned of the allegation of Resident #1 being raped after receiving a telephone call from a stage agency investigator. The Administrator stated, the state agency investigator reported to her that Resident #1 said that a Resident (Resident #4) asked him to give him a blow job. The Administrator stated, "Resident #4 could not have done those things because he was physically [redacted], and they (Resident #1 and #4) have never been roommates." She further stated that Resident #1 was very manipulative and called his dad to make the allegations. According to the administrator Resident #1 was discharged to the hospital on	A 030		

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A 030	Continued From page 9 . . . . . and would not be returning to the facility. Review of Resident #1 hospital records dated . . . . . revealed "the patient has a history of mental illness. The patient claimed that he was . . . . , abused at the ALF and his father is very concern about this event. The administrator of the ALF stated that his ALF is under supervision all the time and the cameras are always on and nothing makes they think he was . . . . . at the ALF, the patient was sent to the hospital because he was violent, intrusive, disorganized and . The patient will be sent to the , center to be evaluated." On the , center was contacted, and a representative reported Resident #1's case was still under review. On . . . . . the police department was notified, and the officer reported Resident #1's case was still open and no records could be released. On at 9:30 AM a telephone interview was conducted with the state agency investigator who advised that Resident #1's case was still under investigation. She stated she had spoken to residents, staff and the administrator at the assisted living facility. She further stated that it seemed there was a history of , inappropriate behavior shown by Resident #1 towards other residents. Interviewed on at 10:12AM Resident #4 stated he never had a conversation with Resident #1. He said, "if I had a problem, I will let the lady know."	A 030		

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A 030	Continued From page 10 On . . . . . at 11:04 AM Resident #2 stated that [Resident #1] was , inappropriate to him. He stated, Resident #1 invited him into the bathroom. He stated, "I reported it to Staff G, and she told me not to worry because he [Resident #1] is leaving the facility anyways." He stated he did not remember the date the incident occurred. On . . . . . at 10:04AM Staff G stated that on one occasion, Resident #2 told her Resident #1 got into the shower with him and told him he wanted to have . Staff G stated, "Resident #1 always want things right away and seem as if he had ( ). Staff G stated she did not remember the date this occurred. On at 11:25 AM an interview was conducted with Staff E and an interpreter. Staff E stated, one day she overheard Resident #2 tell Staff G that the guy (Resident #1) invited him to go to the bathroom to perform acts. Staff E stated she heard Staff G say to Resident #2 that he (Resident #1) was no longer at the facility. Staff E stated she did not recall the date the conversation happened. On at 8:20 AM Resident #3 stated, "I had a problem with a resident (Resident #1) who wanted to have with me." "One day, I don't know the date, I was in the bathroom washing my and he (Resident #1) came inside the bathroom and tried to touch my private parts." "He wanted to lock the bathroom door, but I was able to get out." "I laid down on the bed, then he lowered his pants and showed me his butt, then I left the room". Resident #3 then added that he shared a room with Resident #2 and Resident #2 reported the incident to Staff G.	A 030		

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A 030	Continued From page 11 On [redacted] at 1:30 PM an interview was conducted by telephone with Resident #1. He stated, "A bald man forced and choked me and told me to show him my private parts." "I do not know the name, but he was old and bald." Resident #1 explained sometime in the morning while he was on his bed a man choked him. Resident #1 reported the man was his roommate. Resident #1 said a staff member told him he was lying. He said, "I talked to the supervisor and she told me I lied." Resident #1 explained on another day, while he was in the bathroom, his shorts was off, and a person touched and forced him to have [redacted]. He said it was the same person from the other day. Resident #1 stated, "He had [redacted] in my butt." "He raped me in my butt." "They left after that and the person closed the door."" I told the worker with the blond hair." I told her and explained what happened and she told me I am lying." Resident #1 said he did not remember the dates the incidents occurred. Review of Resident #2 Health Assessment dated [redacted] showed diagnoses of [redacted] type 2, [redacted]. Further review of health assessment revealed that the resident required assistance with medication, independent with eating, toileting, ambulation, and transferring and needed supervision with grooming, bathing and [redacted]. Review of Resident #3 Health Assessment dated [redacted] showed diagnoses of [redacted] Type, [redacted]. Further review of health assessment showed resident is independent with ambulation, eating, toileting and transferring and require supervision with bathing and [redacted].	A 030		

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A 030	Continued From page 12 Review of Resident #4 Health Assessment dated showed diagnoses of type 2, [illegible] and unsteady gait. Resident is independent with eating, toileting and transfers and require assistance with ambulation, bathing and [illegible]. On 2:47 p.m. a telephone interview was conducted with the Administrator. She stated she was aware of Residents #2 and #3's reports of being [illegible] harassed by Resident #1. She stated she changed Resident #3 to another room. The administrator stated staff often redirected Resident #1 from entering females' resident rooms. She stated, Resident #1 reported a resident (Resident #3) had touched his private part's but she did not believed it happened because Resident #3 said he (Resident #1) was the one that pointed at his private part trying to have with him. The administrator stated residents are reminded that they can come to her with any problems. She stated, "staff is trained on reporting [illegible] and my staff knows they cannot withhold any information about allegations." Review of the facility's grievance report dated revealed Resident #1 had reported he was choked and raped by Resident #3. The same grievance report revealed Resident #3 explained Resident #1 was the one that followed him in the bathroom, pointed at his private parts indicating he wanted to have [illegible]. The report revealed Resident #3 was transferred to another room. Review of the grievance report dated for Resident #2 revealed he told Staff G that Resident #1 wanted to have relations.	A 030		

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A 030	Continued From page 13 The grievance report, "action taken section" revealed Resident #1 is not allowed to return to this facility. Review of the grievance report dated revealed Resident #1 reported a resident forced him to give a "blow job". According to Merriam Webster dictionary, 'blow job' is vulgar slang for an act of fellatio. The grievance report, results of investigation section, stated that after interviewing Resident #1, #4, #5,# #14, #15 and Staff D, E, G and N "it was clear the allegations were false." According the facility policy dated revealed," all residents of alleged or suspected must be reported to the administrator, as well as the resident's legal representative or family member, within 24 hours of occurrence of incident. Any reports will trigger immediate investigation of incident. Should the investigation reveal that suspected or actual occurred, the Administrator must report findings to resident's attending physician, legal representative or family member, Department of Children's and families and/or state and federal agencies as required by law". Review of the facility records for Resident #1, #2 and #3 revealed no documentation that the alleged incidents were thoroughly investigated and reported to resident attending physician, responsible party, department of children & families or law enforcement. 2) On at 5:10AM the Staff allowed state agency representatives to enter the facility without conducting a COVID-19 screening. The staff did not take the temperature, complete the	A 030		

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	AL11910926	A. BUILDING: _____ B. WING _____	08/19/2020

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A 030	Continued From page 14 questionnaire form or allowed the state agency representatives to sign in. On at 5:57AM, Staff D asked if anyone had screened the state agency representatives and the answer was no. Staff D then took the agency representatives' temperatures and completed the questionnaire form. On at 5:00 AM Staff H took the agency representatives temperatures and wrote them on a piece of paper. Staff H did not complete the COVID-19 questionnaire or allow the agency representatives to sign in on the record of persons entering the facility. Review of the facility's control policy revealed, "procedure for screening visitors is to stop them at the entrance, take their temperature, have them sanitize their , log the temperatures and fill out a questionnaire about COVID and complete the sign-in log." Class II	A 030		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without	A 078		

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A 078	Continued From page 15 a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with	A 078		

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A 078	Continued From page 16 this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility provided no documentation of a written statement from a health care provider confirming that the individual did not have any signs or symptoms of communicable . . . . . within thirty (30) days of employment for one out of twenty-one sampled staff (Staff C). Findings included: Personnel record review of Staff C showed no documentation that the individual was free of any communicable . . . . . Staff C was hired on . On at 12:30 PM, the Administrator acknowledged that Staff C did not have a written statement from a health care provider on file. Class III	A 078		

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A 081	Continued From page 17	A 081		
A 081 SS=D	59A-36.011( ) FAC Training - Staff In-Service (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement.	A 081		

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A 081	Continued From page 18 (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . . , neglect, and , . The facility must use its . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.	A 081		

Agency for Health Care Administration

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A 081	Continued From page 19 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide in-service training for reporting major incidents; facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation; resident rights in an assisted living facility; recognizing and reporting resident , neglect, and , ; resident behavior and needs; providing assistance with the activities of daily living (ADLs) to facility staff within thirty (30) days of employment for one out of twenty-one sampled staff (Staff B). Findings included: Staff B record review showed there was no documentation of facility's in-service training for reporting major incidents; facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation; resident rights in an assisted living facility; recognizing and reporting resident , neglect, and , ; resident behavior and needs; providing assistance with the activities of daily living (ADLs). Staff B was hired on . On at 12:30 PM, Administrator acknowledged Staff B had no documentation of required facility's in-service training on file. Class III	A 081		