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
	AL11964654	A. BUILDING: _____ B. WING _____	02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST . . . . PLANTATION	2507 OLD ST. . . . . ROAD TALLAHASSEE, FL 32301

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A 000	Initial Comments An unannounced standard biennial relicensure with extended congregate care was conducted at St Plantation on . A focused control survey was conducted in conjunction. At the time of the survey, deficient practice was identified.	A 000		
A 008 SS=D	429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner ' s form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner ' s direct observation of the patient at the time of examination and must include the patient ' s medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form, reflecting the resident ' s condition on the date the examination is performed, becomes a permanent part of the	A 008		

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A 008	Continued From page 1	A 008		

facility ' s record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.
(6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further,

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A 008	Continued From page 2 Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of . . . . . require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or . . . . . services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of . . . . . or any other communicable . . . . , which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care	A 008		

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A 008	Continued From page 3	A 008		

provider, the individual's needs can be met in an assisted living facility; and,
8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S.
(b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed.
1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider.
2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided.
3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823.
(c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the

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A 008	Continued From page 4 administrator using AHCA Form 1823 within 30 days after admission. (d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida . . . . . Form, for residents who do not wish . . . . . to be administered in the case of or . (g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.	A 008		

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A 008	Continued From page 5 This Statute or Rule is not met as evidenced by: Based on resident record review and staff interview, the facility failed to ensure a resident was examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice nurse within 60 days before admission to the facility or within 30 days after admission to the facility. The facility also failed to obtain information omitted on the Health Assessment from the health care provider either orally or in writing to document in the resident's medical record for 1 of 2 resident records reviewed (Resident #10). The findings include: On . . . . , a review of Resident #10's clinical record was conducted. Review of the resident's Facesheet revealed a readmission date of . Review of the resident's Health Assessment (AHCA Form 1823) revealed the date of examination as . Further review of the resident's Health Assessment revealed that subsection D under Section 1 had not been completed, which means there was no answer provided to the following question: "In your professional opinion, can this individual's needs be met in an assisted living facility, which is not a medical, nursing or , ... facility? Additionally, subsection B under Section 2-B had not been completed, which meant that no answer was provided to the following question: Does the individual need help with taking his or her medications (meds)?" On at approximately 4:30 PM, an interview was conducted with the Director of Health & Wellness. The Director of Health &	A 008		

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A 008	Continued From page 6 Wellness confirmed that this was the health assessment that corresponded with the resident's readmission on . . . . . She further confirmed that the examination date was more than 30 days after the resident's admission to the facility and stated that she was unsure why the physician didn't answer those questions. Class	A 008		
A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an . . syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident ' s medications or dosages change. (c) Placing an oral dosage in the resident ' s or placing the dosage in another container and helping the resident by lifting the container to his or her	A 052		

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A 052	Continued From page 7 (d) Applying . . , . . medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a . . . . . , including removing the cap of a . . . . . , opening the unit dose of . . . . . solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . . . . . . (h) Using a . . . . . to perform . . . . . level checks. (i) Assisting with putting on and taking off . . . . . stockings. (j) Assisting with applying and removing an . . . . . but not with titrating the prescribed . . . . . settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with . . . . . bags. (4) Assistance with self-administration does not include: (a) Mixing, ... converting, or . . . . . medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a . . . . of the body. (d) Administration of . . . . . preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with . . . . . , ... , or	A 052		

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A 052	Continued From page 8	A 052		

preparations.
(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.
(h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.
(5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.
59A-36.008
(3) ASSISTANCE WITH SELF-ADMINISTRATION.
(a) Any unlicensed person providing assistance with self-administration of medication must be . . . . . or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule.
(b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed.
(c) In order to facilitate assistance with self-administration, trained staff may prepare and

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A 052	Continued From page 9	A 052		

make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container.
(d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record.
(e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility,
2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record,
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or
4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging.
(f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S.
1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking

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A 052	Continued From page 10 the medication. 2. As used in section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's . . . . control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that the appropriately licensed staff handled the preparation of syringes for injection during medication pass for 1 of 1 residents who received medication by an injectable route (Resident #9). The findings include: On at approximately 12:20 PM, Staff E, an unlicensed med tech, was observed conducting medication pass on the first floor. The surveyor observed Staff E use a . . . . . to obtain Resident #9's . . The . . . reading on the . . . . . was 373. A review of the resident's electronic Medication Observation Record revealed the following order: Admelog . . . . . Injection 100 Units (U) per milliliter (ML), 10 units . three times daily before each meal; inject . three times daily with a correction dose: 200>3U; 250>5U; 300>10U; 350>15U; 400>20U. 100U maximum daily dosage. On at approximately 12:37 PM, an	A 052		

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A 052	Continued From page 11 observation was made of Staff E during medication pass. Staff E explained to the surveyor during the observation that Resident #9 required 25U of . 10U for the regularly scheduled dose and an additional 15U for the correction dose to address the current of 373. Staff E dialed the to 25U and showed it to the resident for confirmation of the 25U to be administered. Resident #9 confirmed the pen was set to administer 25U. Resident #9 took the from Staff E and administered the injection into her left arm. On at approximately 12:40 PM, the surveyor informed Staff E that unlicensed staff are not permitted to dial to which she replied, "Okay, she has to do it?". On at approximately 3:45 PM, an interview was conducted with Resident #9. The surveyor asked if it's common practice for Staff E to dial her for her and she replied, "Yes, or the nurse." Resident #9 further stated that she was a retired nurse practitioner and that she was very upset because she felt like her physician and the facility had mismanaged her since she admitted approximately one year ago. On at approximately 4:00 PM, an interview was conducted with the Director of Health & Wellness. The surveyor asked what the policy is for the handling of by unlicensed staff. The Director of Health & Wellness replied that the unlicensed staff is to inform the nurse so that the nurse can handle, when a resident require a correction dose. A review of the facility's Residency Agreement	A 052		

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A 052	Continued From page 12 was conducted. Record review revealed on page 4 of 54 under section D. Medication Assistance that "'Assistance with Self-Administration' does not include: _ medication dosages; Putting medications in Resident's . . . ; Preparing or administering injections" etc. Class III	A 052		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , . . ., not to exceed 4	A 056		

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A 056	Continued From page 13 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary	A 056		

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	AL11964654	A. BUILDING: _____ B. WING _____	02/23/2021

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A 056	Continued From page 14 prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain a written, faxed, or electronic copy of a medication order signed by the resident's health care provider for a medication in which the facility was providing assistance with self-administration and failed to obtain a revised label from the pharmacist for placement on the prescription pill bottle for 1 of 2 residents observed to receive medications by oral route during medication pass (Resident #10). The findings include: On at approximately 12:20 PM, Staff E, an unlicensed med tech, was observed conducting medication pass on the first floor. The surveyor observed Staff E remove a prescription pill bottle from the medication cart for Resident #10. Staff E showed the surveyor the prescription bottle label which revealed the following order: . . . . . , Capsule 300 MG, take 1 capsule by . . . . three times daily. She then poured 1	A 056		

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A 056	Continued From page 15 capsule from the prescription bottle into a medication cup. Staff E then handed Resident #10 the medication cup with the 1 . . . . . 300 MG Capsule. A review of the resident's electronic Medication Observation Record (MOR) revealed the following order: . Capsule 300 MG, 2 capsules (600 MG) by . . . three times daily for . . On at approximately 4:30 PM, an interview was conducted with the Director of Health & Wellness. The surveyor asked if the order written on the prescription pill bottle or the order that appeared on the MOR was the correct order. She reviewed the resident's medical record and replied that the order on the MOR for 2 . . . . . 300 MG Capsules was the correct order. The surveyor asked the Director of Health & Wellness to locate the original order in the resident's medical record for review. She pointed to an Interdisciplinary Discharge Summary which listed the medications the resident was on at the time of her prior discharge from the facility. The surveyor informed her that that was not an original order signed by the residents physician. The Director of Health & Wellness added that the resident uses a Walmart pharmacy and that the new order just wasn't sent to the pharmacy yet. The surveyor informed the Director of Health & Wellness that the order needed to be shared with the pharmacy as Staff E was only observed to give Resident #10 1 capsule during medication pass. Class III	A 056		

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AE207	Continued From page 16	AE207		
AE207 SS=D	59A-36.021(7) FAC ECC - Services (7) EXTENDED CONGREGATE CARE SERVICES. All services must be provided in the least restrictive environment, and in a manner that respects the resident's independence, privacy, and dignity. (a) A facility providing extended congregate care services may provide supportive services including social service needs, counseling, emotional support, networking, assistance with securing social and leisure services, shopping service, escort service, companionship, family support, information and referral, assistance in developing and implementing self-directed activities, and volunteer services. Family or friends must be encouraged to provide supportive services for residents. The facility must provide training for family or friends to enable them to provide supportive services in accordance with the resident's service plan. (b) A facility providing extended congregate care services must make available the following additional services if required by the resident's service plan: 1. Total help with bathing, , grooming and toileting, 2. Nursing assessments conducted more frequently than monthly, 3. Measurement and recording of basic vital functions and , 4. Dietary management including provision of special diets, monitoring nutrition, and observing the resident's food and fluid intake and output, 5. Assistance with self-administered medications, or the administration of medications and treatments pursuant to a health care provider's order. If the individual needs assistance with self-administration the facility must inform the	AE207		

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AE207	Continued From page 17 resident of the qualifications of staff who will be providing this assistance, and if unlicensed persons will be providing such assistance, obtain the resident's or the resident's surrogate, guardian, or attorney-in-fact's informed written consent to provide such assistance as required in section 429.256, F.S., 6. Supervision of residents with and . . . . . . 7. Health education and counseling and the implementation of health-promoting programs and preventive regimes, 8. Provision or arrangement for rehabilitative services; and, 9. Provision of escort services to health-related . . . (c) Nursing staff providing extended congregate care services may provide any nursing service permitted within the scope of their license consistent with the residency requirements of this rule and the facility's written policies and procedures, provided the nursing services are: 1. Authorized by a health care provider's order and pursuant to a plan of care, 2. Medically necessary and appropriate for treatment of the resident's condition, 3. In accordance with the prevailing standard of practice in the nursing community, 4. A service that can be safely, effectively, and efficiently provided in the facility, 5. Recorded in nursing progress notes; and, 6. In accordance with the resident's service plan. (d) At least monthly, or more frequently if required by the resident's service plan, a nursing assessment of the resident must be conducted. This Statute or Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that monthly nursing assessments were completed by a registered	AE207		

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AE207	Continued From page 18 nurse (RN) for 2 of 2 residents (Resident #2 & 3) reviewed for Extended Congregate Care (ECC) services. The findings include: On . . . . . at approximately 10:15 AM, upon entrance into the facility the Executive Director stated that the Extended Congregate Care Nurse was employee F, a Registered Nurse (RN), but that she had just had a baby so employee C, an Licensed Practical Nurse (LPN) was acting as the ECC nurse while she was on maternity leave. A review of the Nursing Assessment for Extended Congregate Care Services for Resident #2 revealed that the assessments for . , , , , and , had been signed as completed by staff member C, LPN, not a RN. No RN signature was present. A review of the Nursing Assessment for Extended Congregate Care Services for Resident #3 revealed that he assessments for , , , and . , had been signed as completed by staff member C, LPN, not a RN. No RN signature was present. On . . . . . at approximately 3:32 PM, an interview was conducted with the Executive Director and staff member C, LPN. During the interview staff member C, verified that she had completed the Extended Congregate Care Services for Resident #2 for , , , , and . , and for Resident #3 for , , . . . and . . , . She also confirmed that there was not a RN signature on these assessments. At this time the Executive Director explained that staff member F, RN, was coming in to conduct the monthly assessments but that while she was out the	AE207		

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AE207	Continued From page 19 corporate nurse was supposed to sign the monthly assessments behind staff member C, LPN but had not done so while she was there. A review of the facility policy number CL33. FL "Enhanced Congregate Care (ECC) Policy - Florida Only" issued 1.2021 states that "The Registered nurse will participate in the development of resident service plans and perform monthly nursing assessments for extended congregate care residents." According to the Florida Nurse Practice Act, Chapter 464.003, F.S.,"Practice of practical nursing" means the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm; the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse...". "Practice of professional nursing" means the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of , , , biological, physical, and social sciences which shall include, but not be limited to: (a)The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others..." Class III	AE207		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse	CZ814		

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CZ814	Continued From page 20 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the ... are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic ... submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ... ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the employment status for 1 of 4 staff members was maintained on the Agency for Health Care Administration's Background Screening Clearinghouse Roster (staff member F). The findings include: On at approximately 10:15 AM, upon	CZ814		

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CZ814	Continued From page 21 entrance into the facility the Administrator stated that the Extended Congregate Care Nurse was employee F, a Registered Nurse (RN). A review of the Background Screening Clearing House Roster revealed that employee F, RN, was listed as no longer employed by the facility as of . A review of the staff list provided by the facility administrator failed to list employee F. On . . . . . at approximately 2:30 PM, an interview was conducted with the administrator who stated that employee F was indeed employed by the facility as their ECC nurse and that this must be an error on behalf of the Clearinghouse. During the interview the administrator contacted via telephone her corporate office who she stated handles personnel issues such as employment status within the clearinghouse. At this time the Vice President of Clinical Operations informed the Administrator that during a recent visit to the facility it was identified that employee F was listed as an Licensed Practical Nurse (LPN) and not as an RN which is required as part of the ECC certification. She further stated that to change this within the system she had to terminate the employee and then rehire her as an RN. She stated she made this change on . . . . She then sent an email verifying this information on . . . . . at 3:01 PM. At this time, it was determined that the change resulted in the employee being listed as no longer employed on the clearinghouse roster. Unclassified	CZ814		