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
	AL11965763	A. BUILDING: _____ B. WING _____	07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRINGTON TERRACE - FT MYERS	9731 COMMERCE CENTER COURT FORT MYERS, FL 33908

(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
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the [illegible] 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 [illegible] 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; [illegible]; 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 maintain the employment status of all employees within the Agency's Background Screening Clearinghouse and report any changes of status within 10 business days for 5 (Staff A, B, C, D and Resident Care Coordinator) of 6 employees reviewed for the Background	CZ814		

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CZ814	Continued From page 1 Screening Clearinghouse. The findings included: 1. Review of Staff A's file revealed a hire date of as a Resident Aide. Review of the Agency's Clearinghouse Employee Roster revealed Staff A was added onto the Clearinghouse Roster on . Review of Staff B's file revealed a hire date of as the Memory Care Program Director. Review of the Agency's Clearinghouse Employee Roster revealed Staff B was added onto the Clearinghouse Roster on . Review of Staff C's file revealed a hire date of as a Resident Aide. Review of the Agency's Clearinghouse Employee Roster revealed Staff C was not added on the Clearinghouse Roster. Review of the employee file for the Resident Care Coordinator revealed a hire date of . Review of the Agency's Clearinghouse Employee Roster revealed the Resident Care Coordinator was added to the roster on . Review of Staff D's file revealed a hire date of as a Resident Aide. Staff D was listed on the employee list provided at the time of survey. Review of the Agency's Clearinghouse Employee Roster revealed Staff D was still listed and had not been removed from the roster within the 10 days as required. 2. Interview on at 8:53 a.m., the Resident Care Coordinator stated, "Staff D no longer works at the facility, her last date of employment was ."	CZ814		

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CZ814	Continued From page 2 On at 12:18 p.m., the Administrator acknowledged the findings. Unclassified .	CZ814		
CZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ... to the Federal Bureau of Investigation for a national criminal history record check unless the person's ... are enrolled in the Federal Bureau of Investigation's national retained print ... notification program. If the ... of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ... electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ... to the Federal Bureau of Investigation for a national criminal history record check. The ... shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print ... notification program when	CZ816		

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CZ816	Continued From page 3	CZ816		

the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person [illegible]. The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:
(a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section;
(b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and
(c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency.

435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers:
(2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if [illegible] for any of the disqualifying offenses while employed by the employer.

59A-35.090 Background Screening.
(2) Processing Screening Requests, Required

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CZ816	Continued From page 4 Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet 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. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the . . . . report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to	CZ816		

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CZ816	Continued From page 5 disqualification in accordance with Section 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to maintain the signed attestation in the employee's personnel file for 5 (Staff A, B, C, Administrator and Resident Care Coordinator) of 5 personnel files reviewed. The findings included: 1. Staff A's employee file revealed a hire date of [redacted] as a Resident Aide. Staff A's employee file failed to contain a signed attestation. Staff B's employee file revealed a hire date of [redacted] as the Memory Care Program Director. Staff B's employee file failed to contain a signed attestation. Staff C's employee file revealed a hire date of [redacted] as a Resident Aide. Staff C's file failed to contain a signed attestation The Administrator's file revealed a hire date of [redacted]. The Administrator's employee file failed to contain a signed attestation. The Resident Care Coordinator's file revealed a hire date of [redacted]. The Resident Care Coordinator's employee file failed to contain a signed attestation 2. Interview on [redacted] at 12:18 p.m., the Administrator acknowledged the findings. Unclassified	CZ816		

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CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a	CZ830		

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CZ830	Continued From page 7 licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) . . . Licensees providing residential or inpatient	CZ830		

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CZ830	Continued From page 8 services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to submit annually and maintain documentation of a current Comprehensive Emergency Management Plan (CEMP), approved by the local emergency management agency to ensure the safety and welfare of all residents. The findings included: 1. On the Administrator provided a CEMP with an approval letter that indicated the CEMP been approved on . The letter indicated the facility's CEMP was approved through . The letter further indicated a copy of the plan should be submitted to the Emergency Management office before each year for review. Record review of the facility's Emergency Power Plan (EPP) showed it had been approved on , the letter indicated the facility's EPP is approved through . The letter further indicated, going forward the EPP must be included in the facility's annual CEMP submission as an annex/addendum. 2. Interview on at 12:30 p.m., the Administrator said he remembers working on the CEMP for the year 2020. He confirmed he does not have documentation of an approval for the CEMP for the 2020 year. The Administrator	CZ830		

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CZ830	Continued From page 9 stated he has not submitted the facility CEMP this year for 2021. Interview on at 9:25 a.m., the Administrator acknowledged the facility does not have a current approved CEMP. Class .	CZ830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PAVILION OF DOWNTOWN VENICE	200 NASSAU STREET VENICE, FL 34285

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A 000	Initial Comments An unannounced complaint survey for complaint #2021009415 and emergency power plan monitoring, was conducted on through at The Pavilion of Downtown Venice, an assisted living facility in Venice, Florida. Complaint #2021009415 was substantiated at tag A 0200. The following is a description of the deficiency.	A 000		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident	A 200		

AHCA Form 3020-0001

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

Agency for Health Care Administration

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A 200	Continued From page 1	A 200		

must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained.
2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code.
3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment.
a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an

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A 200	Continued From page 2	A 200		

alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary.
b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan.
c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage.
(b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage.
1. Facilities must store minimum amounts of fuel onsite as follows:
a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite.
b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite.

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A 200	Continued From page 3 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . . monoxide alarm. (2) SUBMISSION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency Rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that	A 200		

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(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 200	Continued From page 4 undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than . , have implemented the plan required under this rule.	A 200		

Agency for Health Care Administration

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	AL11963877	A. BUILDING: _____ B. WING _____	07/21/2021

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A 200	Continued From page 5 (b) The Agency shall allow an extension up to , , to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either: a. Fully and safely evacuate its residents prior to the arrival of the event; or	A 200		

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A 200	Continued From page 6 b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to	A 200		

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A 200	Continued From page 7 produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of , and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate	A 200		

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A 200	Continued From page 8 must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) 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: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format, upon request. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to have an operational generator on site at the facility, as stated in their Emergency Power Plan (EPP), for use in the event of the loss of primary electrical power which could affect the residents', health, safety, welfare and comfort in the facility. The facility failed to have monoxide alarms in the facility for use when operating generators in the loss of electrical power as stated in the EPP. The facility	A 200		

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A 200	Continued From page 9 did not have adequate fuel on site for the generators. The findings included: Record review on varified the census was 79; with 3 residents on ; 15 residents with contitions; 27 residents with wheelchairs; and 29 residents with walkers. Interview on at 8:55 a.m., the Maintenance Assistant stated the facility had portable generators which were kept out in a shed. A tour of the shed in the rear of the facility with the Maintenance Assistant revealed no generators. The Maintenance Assistant stated the generators were taken to be fixed at the repair shop. The Maintenance Assistant confirmed the facility had no operational generators onsite at the facility on . Interview on at 9:13 a.m., a tour of the shed at the rear of the facility with the Executive Director, revealed no generators onsite at the facility. The shed contained 2 45-gallon propane tanks and 1 5-gallon gasoline container and 1 5 gallon diesel container. The Executive Director stated the facility had 5 portable generators for use in the event of an emergency for loss of electrical power, she confirmed currently the facility had no operational generators onsite at the facility. Record review of the Emergency Power Plan (EPP) revealed the facility had 4 portable generators that would be used to power portable air conditioning units in the event of loss of electrical power, and 4 monoxide alarms. The evaluation of fuel for the 2018 EPP showed it would take 338 gallons of propane to operate the	A 200		

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A 200	Continued From page 10 4 generators for 96 hours. Interview on at 10:06 a.m., the Service Repair Technician at the repair shop stated the Maintenance Director dropped off the generators last week to be fixed, and the Maintenance Director was informed by the Repair Technician, no one would be able to look at the generators for days. The Service Repair Technician stated the Maintenance Director's reply was, "That's fine he is in no hurry for them." The Service Repair Technician stated they have not looked at the generators yet. Interview on at 1:00 p.m., the Regional Director confirmed the facility does not have an operational generator onsite at the facility for use in the event of loss of electrical power. Interview on at 1:20 p.m., the Maintenance Director confirmed the facility had no operational generators onsite at the facility in the event of loss of electrical power, he said, he tested the generator just when the tropical storm Elsa was supposed to be coming to the state and found the generator was not working. It appeared someone put diesel in the generator, and it needs gasoline to be operational, so he took them to the repair shop to be fixed. He confirmed the facility currently had no operational generators onsite at the facility if they lose power. He states he was not sure how soon they will be getting the generators from the repair shop. He states he never tested the generator until the week when the storm was coming. Review of the EPP indicated the facility had 5 monoxide alarms in the facility for use when operating the portable generators. On at 1:50 p.m., a tour of the main lobby	A 200		

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A 200	Continued From page 11 and memory care living room with the Regional Director and Vice President of Development revealed there were no . . . . . monoxide alarms in the main lobby and memory care living room. The Regional Director confirmed no . . . . . monoxide alarms were in the facility in the main lobby and memory care living room as indicated in the plan. She said, "I will go to the store and buy some." A monitoring visit on . . . . at 2:30 p.m., revealed 2 operational generators and 2 non-operational generators had been returned by the Service Repair Company. Two of the 4 generators did not operate when tested. Class II .	A 200		

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BARRINGTON TERRACE - FT MYERS	9731 COMMERCE CENTER COURT FORT MYERS, FL 33908

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A 000	Initial Comments An unannounced biennial, emergency power plan monitoring, extended congregate care and complaint survey for complaint #2021005011 was conducted on . . . through . . . . . at Barrington Terrace - Fort Myers, an assisted living facility in Fort Myers, Florida. Complaint #2021005011 had 1 allegation which was substantiated without citation. The following is a description of the deficiencies: .	A 000		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of . . . . . testing materials satisfies the annual . . . examination requirement. An individual with a positive . . . . . test must submit a health care provider's statement that the individual does not constitute a risk of .	A 078		

AHCA Form 3020-0001

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

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A 078	Continued From page 1 2. If any staff member has, or is suspected of having, a communicable [redacted], 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 [redacted]. (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 [redacted] to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff [redacted] by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.	A 078		

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A 078	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure that within 30 days of employment staff submit a written statement from a health care provider documenting the individual is free from signs/symptoms of communicable ( )and evidence of freedom from documented annually thereafter for 5 (Staff A, B, C, Administrator and Resident Care Coordinator) of 5 employee records reviewed. The findings included: 1. On , a review of the Administrator's file revealed a hire date of . The Administrator's file contained documentation of a skin test ( ) performed on and . The Administrator's file contained no documentation of a statement from a health care provider which indicated that the Administrator was free of signs and or symptoms of communicable . On , a review of Staff A's employee file revealed a hire date of as a resident aide. Staff A's file contained no documentation of a statement from a health care provider that indicated Staff A was free from signs or symptoms of communicable including . On , a review of Staff B's employee file revealed a hire date of as the Memory Care Program Director. Staff B's file contained no documentation of a statement from a health care provider that indicated that Staff B was free from signs or symptoms of communicable including .	A 078		

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A 078	Continued From page 3 On , a review of Staff C's employee file revealed a hire date of as a resident aide. Staff C's file contained no documentation of a statement from a health care provider that indicated that staff C was free from signs or symptoms of communicable including . On , a review of the Resident Care Coordinator's employee file revealed a hire date of . The Resident Care Coordinator's file contained documentation of a tests performed on and . The Resident Care Coordinator's file contained no documentation of a statement from a health care provider that indicated that the Resident Care Coordinator was free from signs or symptoms of communicable including . 2. Interview on at 12:18 p.m., the Administrator acknowledged the findings. Class III .	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1)Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility	A 081		

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A 081	Continued From page 4 must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (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 081		

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A 081	Continued From page 5 (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 [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (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 [illegible], neglect, and [illegible]. The facility must use its [illegible] 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.	A 081		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 081	Continued From page 6 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure facility employees complete a 2 hour pre-service orientation prior to interacting with residents and failed to ensure staff participate in in-service training which includes 3 hours of in-service training for Activities of Daily Living and Behavioral needs, and 1 hour of in-service training for Nutritional Safe Food Handling, Control, Reporting Major Incidents, Reporting Adverse Incidents and Facility Emergency Procedures, Resident Rights, Recognizing/Reporting /Neglect, Incident Reporting training and Elopement Response Training, as required by Florida Administrative Code within 30 days of employment for 4 (Staff A, B, C, and Resident Care Coordinator) of 5 employee files reviewed.	A 081		

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	AL11965763	A. BUILDING: _____ B. WING _____	07/08/2021

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A 081	Continued From page 7 The findings included: 1. On , record review of Resident Care Coordinator, Resident Aide Staff A, Memory Care Program Director Staff B, and Resident Aide Staff C personnel records revealed the following: The Resident Care Coordinator's file revealed a hire date of . The Resident Care Coordinator's file did not contain documentation of completing a minimum 1 hour in-service training in Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Elopement Response Training, and Nutritional and Safe Food Handling within 30 days of employment. Resident Aide Staff A's file revealed a hired date of . Staff A's file did not contain documentation of completing a minimum 3 hour in-service on Activities of Daily Living (ADL) and Behavioral Needs, a minimum 1 hour in-service training in Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Elopement Response Training, Incident Reporting Training, Resident Rights and Recognizing and Reporting /Neglect Training, and Nutritional and Safe Food Handling within 30 days of employment. Resident Aide Staff B's employee file revealed a hire date of . . . . . Staff B's file did not contain documentation of completing a minimum 1 hour in-service in Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Resident Rights and Recognizing/Reporting /Neglect training and Nutritional and Safe Food Handling within 30 days of employment.	A 081		

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A 081	Continued From page 8 Resident Aide Staff C's employee file revealed a hire date of . . . . . Staff C's file did not contain documentation of completing 2 hour pre-service orientation prior to interacting with residents, a minimum 3 hour in-service training for ADL and Behavioral Needs, a minimum 1 hour in-service training in Reporting Major Incidents, reporting Adverse Incidents, Facility Emergency Procedures, Nutritional and Safe Food Handling, Elopement Response, Resident Rights and Recognizing/Reporting . /Neglect, Incident Reporting Training, and . . . . . Control Training within 30 days of employment. 2. Interview on at 12:18 p.m., the Administrator reviewed and confirmed Staff A, B, C, and the Resident Care Coordinator Director did not have all the required in-services within 30 days of their employment. Class III .	A 081		
A 082	59A-36.011(4) FAC Training - / . . (4) . . . . / . . . . (. . / . . .). Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule.	A 082		

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A 082	Continued From page 9 This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure facility employees complete a one-time education course on and (/) within 30 days of employment for 1 (Staff C) of 5 employee files reviewed for / training. The findings included: 1. On , record review of Staff C's employee file revealed a hire date of as a resident aide. Staff C's file contained no evidence of training being completed within 30 days of employment for / . 2. Interview on at 12:18 p.m., the Administrator acknowledged Staff C's filed contained no documentation of the training being completed. Class III .	A 082		
A 086	59A-36.011(10) FAC Training - ADRD (10) AND RELATED ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct	A 086		

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A 086	Continued From page 10 care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between , , , and , , shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled " and Related Level I Training," must address the following subject areas: 1. Understanding 's and related ; 2. Characteristics of ; 3. Communicating with residents with 's ; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility and Related Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled " and Related Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. and Related Level II Training must address the following subject areas as they apply to these : 1. Behavior management,	A 086		

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A 086	Continued From page 11 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with 's and Related ," dated , incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with	A 086		

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A 086	Continued From page 12 . . . . . or related . . . . . , or 2. Three years of practical experience in a program providing care to persons with . . . . . or related . . . . . , or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with . . . . . or related . . . . . . (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review, and staff interview, the facility failed to ensure staff completed 4 hours of Level I . . . . . training within 3 months of hire and 4 hours of Level II . . . . . 's and related . . . . . training within 9 months of hire as required by the Florida Administrative Code for 5 (Staff A, B, C, Administrator and Resident Care Coordinator) out of 5 staff reviewed. This facility has 2 secured Memory Care Units. The findings included: 1. Record review found Staff A was hired on . . . . . as a Resident Aide. Initial record review found no documentation of Level I . . . . . 's training completed within 3 months as is required. Record review found Staff B was hired on . . . . . as the Memory Care Program Director. Initial record review found no documentation of level I	A 086		

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A 086	Continued From page 13 . . . . . training completed within 3 months as is required, and no documentation of Level II . . . . . training completed within 9 months of hire as is required. Record review found Staff C was hired on as a Resident Aide. Initial record review found no documentation of Level I 's training completed within 3 months as is required. Record review found the Administrator was hired on . Initial record review found no documentation of Level I . . . . . 's training completed within 3 months as is required, and no documentation of Level II . . . . . 's training completed within 9 months of hire as is required. Record review found the Resident Care Coordinator was hired on . . . . . Initial record review found no documentation of Level I . . . . . training completed within 3 months as is required, and no documentation of Level II . . . . . training completed within 9 months of hire as is required. 2. Interview on at 12:18 p.m., the Administrator reviewed the employee files and acknowledged the findings of the missing required trainings. Class III .	A 086		
A 090	59A-36.011(11) FAC Training - . . . . . . (11) . . . . . TRAINING. (a) Currently employed facility administrators,	A 090		

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A 090	Continued From page 14 managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policies and procedures regarding . (b) Newly hired facility administrators, managers, direct care staff and staff involved in resident admissions must receive at least one hour of training in the facility's policy and procedures regarding within 30 days after employment. (c) Training shall consist of the information included in rule 59A-36.009, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure facility employees complete at least one hour of in-service training in the facility's policies and procedures regarding ( ) within 30 days after employment and maintain documentation of completion for 5 (Staff A, B, C, Administrator, Resident Care Coordinator) of 5 employee files reviewed. The findings included: 1. On , record review of Staff A's employee file revealed a hire date of as a Resident Aide. Staff A's file contained no documentation of having completed an in-service on within 30 days of hire. On , record review of Staff B's employee file revealed a hire date of as the Memory Care Program Director. Staff B's file contained no documentation of having completed an in-service on within 30 days of hire. On , record review of Staff C's employee	A 090		

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A 090	Continued From page 15 file revealed a hire date of as a Resident Aide. Staff C's file contained no documentation of having completed an in-service on within 30 days of hire. On , record review of the Administrator's employee file revealed a hire date of . The Administrator's file contained no documentation of having completed an in-service on within 30 days of hire. On , record review of the Resident Care Coordinator's employee file revealed a hire date of . The Resident Care Coordinator's file contained no documentation of having completed an in- service on within 30 days of hire. 2. Interview on at 12:18 p.m., the Administrator reviewed the employee files and acknowledged the findings of the missing in-service trainings required for Class III	A 090		
A 091	59A-36.011(12) FAC Training - Documentation & Monitoring (12) TRAINING DOCUMENTATION AND MONITORING. (a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following: 1. The title of the training program, 2. The subject matter of the training program,	A 091		

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A 091	Continued From page 16 3. The training program agenda, 4. The number of hours of the training program, 5. The trainee's name, dates of participation, and location of the training program, 6. The training provider's name, dated signature and credentials, and professional license number, if applicable. (b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule. (c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory requirements. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to appropriately document required trainings for 4 (Administrator, Staff A, B, Resident Care Coordinator) of 5 employee records reviewed. The findings included: 1. Record review for the Administrator revealed a hire date of [redacted]. Further review revealed a certificate of completion dated [redacted] for Arbor General Orientation. The certificate did not include, the agenda, the trainer's name, credentials and signature. Record review for Staff A revealed a hire date of [redacted] as a Resident Aide. Further review revealed a certificate of completion dated [redacted] for General Orientation. The certificate did not	A 091		

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A 091	Continued From page 17 include the hours, the trainer's name, credentials and signature. Record review for Staff B revealed a hire date of [redacted] as the Memory Care Program Director. Further review revealed a certificate of completion dated [redacted] for Arbor General Orientation. The certificate did not include, the agenda, the trainer's name, credentials and signature. Record review for the Resident Care Coordinator revealed a hire date of [redacted]. Further review revealed a certificate of completion dated for Arbor General Orientation. The certificate did not include, the agenda, the trainer's name, credentials and signature. 2. Interview on [redacted] at 12:18 p.m., the administrator reviewed the employee files and confirmed the pre-service orientation training certifications on file did not meet regulatory requirements. Class .	A 091		