

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
---	--	--	--

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
{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 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 _____. 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	{CZ816}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{CZ816}	Continued From page 1 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 _____ for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required 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_Service	{CZ816}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{CZ816}	Continued From page 2 s/Background_Screening/Regulations_Forms.sht ml. 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 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 ensure all staff who are required to be screened have an Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008 on file upon hire for 3	{CZ816}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{CZ816}	Continued From page 3 (Administrator, Resident Care Coordinator, and Staff A) of 8 employees reviewed. This is an uncorrected deficiency from The findings include: 1. Record review on of the Administrator's employment file revealed he was hired on An Attestation dated was found in his record. Interview on at 2:57 p.m., the Administrator verified he had not signed the Attestation form in his file. He verified he was not a cook at this facility in 2018 as he moved down to Florida in Interview on at 2:57 p.m., the Business Office Director (BOD) said she found the form in the Attestation book and thought it was the Administrator's and added it to his file. She verified there was no Attestation signed to date. 2. Record review on of the Resident Care Coordinator's employment file revealed she was hired on, and had no Attestation form on file. Interview on at 3:02 p.m., the Business Office Director (BOD) verified there was no Attestation signed to date. 3. Record review on of the Resident Aide- Memory Care Staff A's employment file revealed she was hired on, and had no Attestation form on file. Interview on at 3:06 p.m., the Business Office Director (BOD) verified there was no Attestation signed to date.	{CZ816}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{CZ816}	Continued From page 4 Class III	{CZ816}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
---	--	--	--

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
{A 000}	Initial Comments A follow-up by desk review was conducted on through for Barrington Terrace - Fort Myers, an assisted living facility in Fort Myers, Florida. The follow-up was in response to the complaint survey completed on The following is description of the new or uncorrected deficiencies found at the time of the visit.	{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

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{A 078}	Continued From page 1 2. If any staff member has, or is suspected of having, a communicable _____, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable _____. (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility _____ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff _____ by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.	{A 078}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{A 078}	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on record review, and interviews, the facility failed to ensure all staff had a freedom from communicable _____ statement from a health care provider in the file within 6 months of hire or 30 days after hire and a negative _____ result or health care provider's statement that the individual does not constitute a risk of _____ annually thereafter for 6 (Administrator, Resident Care Coordinator, Staff A, B, C and G) of 8 staff reviewed. This is an uncorrected deficiency from _____. The findings included: - Record review on _____ of the Administrator's employment file revealed the Administrator was hired on _____ and had no freedom from communicable _____ in the file. A negative _____ test was read by a nurse on _____ (more than 30 days after hire). The Administrator also had no negative _____ result or health care provider's statement that the individual does not constitute a risk of communicating _____ for 2021. - Interview on _____ at 2:57 p.m., the Administrator and Business Office Director (BOM) verified the the facility had no communicable _____ statement or annual negative _____ on file for the Administrator. - Record review on _____ of the Resident Care Coordinator's (RCC) employment file revealed the RCC was hired on _____ and had no freedom from communicable _____ in the file. A _____ test was read by a nurse on _____ No negative _____ statement was on file.	{A 078}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
{A 078}	Continued From page 3 Interview on _____ at 2:57 p.m., the Administrator and Business Office Director (BOM) verified the the facility had no communicable _____ or annual freedom from statement on file for the RCC. 3. Record review on _____ of the Resident Aide- Memory Care Staff A's employment file revealed she was hired on _____, and had no freedom from communicable _____ statement on file. Staff A did have a negative _____ result on _____. She also had no negative _____ result or health care provider's statement that the individual does not constitute a risk of communicating _____ for 2021. Interview on _____ at 3:06 p.m., the Business Office Director (BOD) verified there was no communicable _____ statement or annual negative _____ on file for 2021. 4. Record review on _____ of the former Memory Care Director Staff B's employment file revealed she was hired on _____, and had no freedom from communicable _____ statement on file. Staff B did not have a negative _____ result for 2020 or 2021. She separated from employment on _____. Interview on _____ at 2:16 p.m., the Business Office Director (BOD) verified there was no communicable _____ statement or annual negative _____ on file for 2020 or 2021. 5. Record review on _____ of the Resident Aide Staff C's employment file revealed she was hired on _____, and had no freedom from communicable _____ statement on file.	{A 078}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
---	--	--	--

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
{A 078}	Continued From page 4 Interview on at 3:11 p.m., the Business Office Director (BOD) verified there was no communicable statement on file for 2021. 6. Record review on of the Licensed Practical Nurse Staff G's employment file revealed he was hired on and had no freedom from communicable statement on file. Interview on at 4:05 p.m., the Business Office Director (BOD) verified there was no communicable statement on file for 2021. 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 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	{A 081}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
{A 081}	Continued From page 5 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) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in _____ control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its _____ control policies and procedures when offering this training. Documentation of	{A 081}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
---	--	--	--

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
{A 081}	Continued From page 6 compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , , , , , neglect, and . The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty	{A 081}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS			STREET ADDRESS, CITY, STATE, ZIP CODE 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
{A 081}	Continued From page 7 (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 all new employees complete a 2 hour pre-service orientation prior to interacting with residents which includes Resident Rights and the facilities license type and services offered by the facility; Failed to ensure that direct care staff receive the a 1 hour inservice in _____ Control from the facility's own policy and procedure before providing personal care to residents; Failed to ensure that all staff receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment; Failed to ensure direct care staff receive the following training within 30 days of hire: 1. Reporting adverse incidents and the Facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation, 1 hour; 2. Resident rights, and Recognizing and reporting resident _____, neglect, and _____. The facility must use its _____ prevention policies and procedures when offering this training, 1 hour; 3. 3 hours of in-service training in Resident behavior and needs, and Providing assistance with the activities of daily living;	{A 081}			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
---	--	--	--

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
{A 081}	Continued From page 8 for 8 (Administrator, Resident Care Coordinator, Staff A, B, C, D, E, F, and G) of 8 staff reviewed. This is a repeat deficiency. The findings included: 1. A review of the curriculum for the 5 hour Arbor General Orientation revealed the course did include Resident Rights, but did not include the Facility's license type and services offered. Although General Orientation was attended by all staff, it did not include a required topic. 2. A review of the Control training revealed it was provided through an on-line program for the Administrator, Staff C and Staff F. The Administrator and Staff C also had a certificate which said it was provided by a staff nurse with a date. No nurse's name, dated signature or credential was included on the certificate. Only the name of the attendee and date was filled in. 3. A review of the Elopement training revealed the on-line course was for a half an hour. None of the staff had elopement training from the facility's own policy and procedure. The Administrator, Resident Care Coordinator, and Staff A, B and C lacked documentation of Elopement training from any source. Staff E, F, and G had the on-line course. 4. A review of employment records for the Administrator, Resident Care Coordinator, Staff A, B, C, D, E, F, and G lacked training in adverse incidents and reporting and , neglect and . Staff C who had a certificate in , neglect and , lacked the time frame of the training, trainer, dated signature or agenda and subject matter.	{A 081}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
{A 081}	Continued From page 9 5. A review of the curriculum for training failed to find training on activities of daily living. Multiple trainings contained assistance and communication, behaviors and working with residents. The Resident Care Coordinator and Staff A had a certificate with only the attendees name and date filed in. 6. Interview on _____ at 2:16 p.m., the Business Office Manager verified the employee records were incomplete. She verified she was attempting to provide certificates with all the required information on them, but did not know what Florida required and could not really recreate past certificates as she did not know who the trainers were. 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. This Statute or Rule is not met as evidenced by: Based on record review, and interview, the facility failed to ensure direct care staff have training in	{A 082}	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
---	--	--	--

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
{A 082}	Continued From page 10 (/) within 30 days of hire for 1 (Staff F) of 8 staff records reviewed. This is an uncorrected deficiency from The findings included: Record review on of the Resident Assistant - Memory Care Staff F's employment file revealed she was hired on, and had no / training on file. Interview on at 4:00 p.m., the Business Office Director (BOD) verified there was no / training on file for Staff F. Class III	{A 082}		
{A 090}	59A-36.011(11) FAC Training - (11) TRAINING. (a) Currently employed facility administrators, 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:	{A 090}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
---	--	--	---

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
{A 090}	Continued From page 11 Based on record review, and interview, the facility failed to ensure that administrators, 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 () within 30 days of hire for 8 (Administrator, Resident Care Coordinator, Staff A, B, C, D, E, F, and G) of 8 staff reviewed. This is an uncorrected deficiency from . The findings included: 1. Record review on of the Administrator's employment file revealed the Administrator was hired on . and had no . training in the file. Interview on . at 2:57 p.m., the Administrator and Business Office Director (BOM) verified the facility had no . training on file for the Administrator. 2. Record review on of the Resident Care Coordinator's (RCC) employment file revealed the RCC was hired on . and had no . training in the file. Interview on . at 2:57 p.m., the Administrator and Business Office Director (BOM) verified the the facility had no . training on file for the RCC. 3. Record review on of the Resident Aide- Memory Care Staff A's employment file revealed she was hired on ., and had no . training on file. Interview on . at 3:06 p.m., the Business Office Director (BOD) verified there was no	{A 090}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
---	--	--	--

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
{A 090}	Continued From page 12 training on file. 4. Record review on _____ of the former Memory Care Director Staff B's employment file revealed she was hired on _____, and had no training on file. She separated from employment on _____. Interview on _____ at 2:16 p.m., the Business Office Director (BOD) verified there was no training on file. 5. Record review on _____ of the Resident Aide Staff C's employment file revealed she was hired on _____, and had no training on file. Interview on _____ at 3:11 p.m., the Business Office Director (BOD) verified there was no training on file. 6. Record review on _____ of the Licensed Practical Nurse Staff E's employment file revealed she was hired on _____, and had no training on file. Interview on _____ at 4:05 p.m., the Business Office Director (BOD) verified there was no training on file. 7. Record review on _____ of the Resident Aide Staff F's employment file revealed she was hired on _____, and had no training on file. Interview on _____ at 3:11 p.m., the Business Office Director (BOD) verified there was no training on file. 8. Record review on _____ of the Licensed	{A 090}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{A 090}	Continued From page 13 Practical Nurse Staff G's employment file revealed he was hired on _____, and had no _____ training on file. Interview on _____ at 4:05 p.m., the Business Office Director (BOD) verified there was no _____ training on file. 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, 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,	{A 091}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
NAME OF PROVIDER OR SUPPLIER BARRINGTON TERRACE - FT MYERS		STREET ADDRESS, CITY, STATE, ZIP CODE 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
{A 091}	Continued From page 14 which is intended to meet regulatory requirements. This Statute or Rule is not met as evidenced by: Based on record review and interview, all training required by Florida Administrative Code 59A-36.011 must be documented in the facility's personnel files and include the following: 1. The title of the training program, 2. The subject matter of the training program, 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; Failed to ensure that Control Training, Elopement, , and , Neglect and and must be taught from the Facility's own policy and procedures; For 8 (Administrator, Resident Care Coordinator, Staff A, B, C, E, F, and G) of 8 employee records reviewed. The findings included: A review on of the Administrator, Resident Care Coordinator, Staff A, B, C, E, F, and G's employee files revealed various certificates for the required trainings which lacked the subject mater, program agenda, hours of the training program, location of training, and the trainers name, dated signature and credentials. Interview on at 2:16 p.m., the Business Office Manager verified the employee records were incomplete. She verified she was attempting to provide certificates with all the required	{A 091}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965763	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/15/2021
---	--	--	--

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
{A 091}	Continued From page 15 information on them, but did not know what Florida required and could not really recreate past certificates as she did not know who the trainers were. She verified the certificates for the Facility lacked one or more of the following: subject mater, program agenda, location of training, the trainers name, dated signature and credentials and hours of the training program. She further verified the on-line training program lacked the agenda and subject matter. She demonstrated the agendas had to be printed separately for the on-line courses and did not include subject matter. Class III	{A 091}		