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
	AL11969569	A. BUILDING: _____ B. WING _____	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CLUB AT BOYNTON BEACH	623 S FEDERAL HIGHWAY LAKE WORTH, FL 33463

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A 000	Initial Comments An unannounced Relicensure with Limited Nursing Services (LNS), Complaint (2024011964, 2024014264, 2024014947) and a Generator Monitoring survey was conducted on through at The Club at Boynton Beach. The facility had deficiencies identified related to the Relicensure, Complaint (2024014947) and Generator Monitoring at the time of the survey.	A 000		
A 036	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, , handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an , exposure to transmissible agents in , , , , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, , protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations.	A 036		

AHCA Form 3020-0001

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

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A 036	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the safety of residents by establishing/or maintaining Control procedures and processes to prevent the outbreak of a food-borne illnes. And failure to report an occurring in the facility to the proper authorities/or agencies. The findings include: In an interview with the Director of Wellness, Staff H on at 3:45 PM, this surveyor made a request to her for the facility's Policies & Procedures, specifically their Control policy. She stated she would make it available for review. On , this surveyor was provided with the facility's "Standards Guidelines, Policies & Procedures, Resident Agreement, Resident Handbook." A review of the binder (Handbook) revealed policies and procedures for various matters, but did not reveal a policy for control. During an interview on at 11:45 AM with the Director of Dining, Staff E, he stated to the surveyor that that he has been working at the facility since . When asked about the outbreak at the facility in , Staff E stated that he was informed by a former staff member (Nurse who is no longer at the facility), that the facility had 3 or 4 residents who were with . He further the residents were in placed in and the dietary staff used personal protective equipment and disposable plates for everyone.	A 036		

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A 036	Continued From page 2 In a confidential telephone interview on at 10:01 AM, the interviewee stated there was an outbreak at the facility a few months before, which resulted in at least three (3) residents getting sick. The interviewee stated they could not remember the names of the residents but stated the facility did not report the incident to the State, or anyone. On at 10:39 AM, this surveyor received a call from the confidential interviewee, who stated the outbreak occurred in of 20204 and became known on . He/She stated Resident #14 and Resident #15 who resides in the Memory Care Unit (MCU were two of the three residents . He/She further stated that (a local lab) came onsite and conducted testing, which resulted in both Resident #14 and #15 testing positive for . On at between 12:19 PM and 12:31 PM, this surveyor attempted to interview Resident #14 but was unable to conduct an interview with him. Resident #15 was not available for interview. In an interview on at 2:00 PM with the Administrator, Staff A and Director of Wellness, Staff H, the Administrator stated that three residents were , , and that no one was hospitalized. He stated the residents during a meal in the dining room. He stated he could not recall the names of the three residents, and that no one ate the same food, and that their symptoms appeared on different days. This surveyor asked if the illness was reported to the Department of Health, or the Agency for Health Care Administration, and he stated he was not sure. He stated that the Director of Nursing at the time, was asked to report it. However, he was not sure if she did or not. He further stated the	A 036		

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A 036	Continued From page 3 nursing director interviewed the residents DON, he/she stated he doesn't remember if any labs were taken. In an interview with the Administrator, Staff A and Director of Wellness, Staff H on at 2:38 PM the Administrator stated he was not sure if the family members were notified as the Director of Nursing at the time would have done so. A review of the facility's files and documents provided during the survey did not reveal any documentation that the outbreak was ever reported to either agency, the residents family or responsible party. No documentation regarding the outbreak was provided during the survey. Class III	A 036		
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	A 078		

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A 078	Continued From page 4 provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with 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	A 078		

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A 078	Continued From page 5 position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure staff had documented evidence of a negative ( ) examination and Communicable Status for 4 out of 4 sampled Staff (Staff A, B, C and D). The findings included: 1) Review of the personnel file for Staff A (Administrator) with a hire date of . Further review revealed Staff A, did not have documented evidence of annual negative for 2023 (require within 30 days of hire) and thereafter, and Communicable Status within 30 days of hire in his employee file. 2) Review of the personnel file for Staff B (Home Health Aid) with a hire date of . Further review revealed Staff B did not have documented evidence of annual negative and Communicable Status within 30 days of hire in her employee file. 3) Review of the personnel file for Staff C (Home Health Aid) with a hire date of . Further review revealed Staff C did not have documented evidence of annual negative for 2024 and Communicable Status within 30 days of hire in his employee file.	A 078		

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A 078	Continued From page 6 4) Review of the personnel file for Staff D (Facility Nurse) with a hire date of . Further review revealed Staff D did not have documented evidence of annual negative and Communicable Status within 30 days of hire in her employee file. During an interview on at approximately 4:5 PM the Administrator acknowledged the findings. No additional documentation was provided during the survey. Class III	A 078		
A 080	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting , neglect, and , . (c) Special needs of elderly persons, persons with	A 080		

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A 080	Continued From page 7 mental illness, and persons with , and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with 's and related . 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , and managers who attended the core training program prior to , , shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate	A 080		

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A 080	Continued From page 8 in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that, the facility failed to provide the Administrator's completed CORE training and Exam Completion date require documentation. The findings included: During an interview on at approximately 11:35 AM with the Administrator he was informed to provide documentation of his completed CORE training and Exam Completion date. A review of the Administrator's personnel file revealed he was hired on . Further review revealed no documentation in his file for	A 080		

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A 080	Continued From page 9 completed CORE training and Exam Completion date. During an interview on at approximately 4:25 PM with the Administrator he acknowledged the findings. No additional documentation was provided during the survey. Class III	A 080		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52 (1)(a) 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. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a).	A 081		

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A 081	Continued From page 10 (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) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule	A 081		

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A 081	Continued From page 11 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (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	A 081		

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A 081	Continued From page 12 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, it was determined that, the facility failed to ensure direct care staff had completed the required pre-service training and required direct care training within 30 days of hire, for 3 out of 4 sampled staff (Staff B, C and D). The findings included: 1) Review of the personnel file for Staff B (Home Heath Aid) with a hire date of . Staff B did not have Preservice Orientation documenting In-Service Training, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting Training, Resident Rights and Recognizing / Reporting /Neglect Training in her employee file.	A 081		

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A 081	Continued From page 13 2) Review of the personnel file for Staff C (Home Heath Aid) with a hire date of . Staff C did not have Preservice Orientation documenting In-Service Training, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting Training, Resident Rights and Recognizing / Reporting /Neglect Training in his employee file. 3) Review of the personnel file for Staff D (Facility Nurse) with a hire date of . Staff D did not have Preservice Orientation documenting In-Service Training, Reporting Major Incidents, Reporting Adverse Incidents, Facility Emergency Procedures, Incident Reporting Training, Resident Rights and Recognizing / Reporting /Neglect Training in her employee file. During an interview on at approximately 4:25 PM the Administrator acknowledged the findings. No additional documentation was provided during the survey. 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	A 082		

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A 082	Continued From page 14 this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure that within 30 days of employment staff obtained required training for / / (/ /) for 3 out of 4 sampled staff (Staff B, C, and D). The findings included: 1) Review of the personnel file for Staff B (Home Heath Aid) with a hire date of . Staff B did not have documentation for / training in her personnel file. 2) Review of the personnel file for Staff C (Home Heath Aid) with a hire date of . Staff C did not have documentation for / training in her personnel file. 3) Review of the personnel file for Staff D (facility nurse) with a hire date of . Staff D did not have documentation for / training in his personnel file. During an interview on at approximately 4:25 PM the Administrator acknowledged the findings. No additional documentation was provided during the survey. Class III	A 082		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS.	A 152		

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	AL11969569	A. BUILDING: _____ B. WING _____	04/15/2025

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A 152	Continued From page 15 (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to timely ensure That all existing	A 152		

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A 152	Continued From page 16 architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order (Fire Panel/Fire Sprinkler). The findings include: In an interview with the Administrator, Staff A on at 10:04 AM, a request was made for the facility's recent Fire Inspection letter. He stated he would have the Maintenance Director provided the information requested. In an interview with the Maintenance Director, Staff I and Administrator, Staff A on at 10:32 AM they provided this surveyor with their most recent Fire Inspection report from the Local Fire Rescue - Fire & Life Safety Division dated which documented there were violations identified (copy obtained). The Maintenance Director stated in the interview that they are working on the violations and have entered into an agreement with a new Fire Alarm company who will be onsite to address the issues. In an interview with the Maintenance Director, Staff I on at 11:15 AM he provided this surveyor with the Agreements with EverOn, the new company for the Fire Panel, Fire Sprinklers, and Bi-Directional Amplifier (BDA) System to do monitoring and inspections (copies obtained). Observation by this surveyor on at 1:04 PM was made of the trash chute inside the Trash Chute door in the Memory Care Unit (MCU). Observation revealed the floor was dirty, sticky and had debris on it (photo obtained). On at 4:53 PM the survey team met	A 152		

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A 152	Continued From page 17 with the Administrator and Director of Wellness to conduct the Exit Conference. They were informed of the findings of the survey. Class III	A 152		
A 161	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff training and continuing education required by Rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in Section	A 161		

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A 161	Continued From page 18 429.174, F.S., and Rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to Rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ␣ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in Rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by Rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure staff record contained an employment application with references for 1 out of 3 sample staff (Staff A). The findings included: A review of the personnel file for Staff A (Administrator) revealed he was hired on ␣. Further review revealed an employment application with no references. During an interview on at approximately 4:25 PM with the Administrator he acknowledged the findings. No additional documentation was provided during the survey.	A 161		

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A 161	Continued From page 19 Class	A 161		
A 162	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the resident's health care practioner and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 or the health care practitioner's medical examination form described in Rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to Rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(f), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823	A 162		

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A 162	Continued From page 20 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. This subsection does not apply to residents who are receiving licensed hospice services when such residents, their representatives, or their physicians request in writing that not be taken. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in Rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to Rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in Rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in Section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in Section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No	A 162		

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A 162	Continued From page 21 =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in Rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to a log listing the names of residents participating in this arrangement. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility	A 162		

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A 162	Continued From page 22 failed to ensure that resident records were retained at the facility and made available for review for two of two Residents reviewed (Resident #1 and #2). The findings include: In an interview with the Administrator,Staff H on at 9:32 AM, a request was made to him for the facility files for Residents #1 and #2. He stated he was not sure if they were there and went to look for them. In an interview with the Administrator on at 11:03 AM he stated the resident files Resident #1 and Resident #2 is in their files/documents were in their company's storage. He stated he put in a call to the company to deliver them, but it won't be until tomorrow. In an interview with the Administrator on at 2:45 PM he stated he contacted their document storage company again to see if they could expedite the files (coming to the facility) but haven't gotten a response yet. The files for Residents #1 and #2 were not provided for review during the survey. Class	A 162		
AN278	59A-36.022(3) FAC; 429.07(3)(c)2, FS LNS - Records 59A-36.022 (3) RECORDS. (a) A record of all residents receiving limited nursing services and the type of services provided must be maintained at the facility. (b) Nursing progress notes must be maintained	AN278		

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AN278	Continued From page 23 for each resident who receives limited nursing services from facility staff. (c) A nursing assessment conducted at least monthly must be maintained on each resident who receives a limited nursing service. 429.07 (3)(c)2, FS A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services from the facility's staff. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health... This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete the required monthly Nursing Assessment for resident care for 2 of 2 sampled residents receiving Limited Nursing Service (LNS) Resident #16 and Resident #7. The findings include: 1. Resident #16 was admitted to the facility with medical history including , . Resident #16 was recently admitted to the memory care unit of the facility and requires assistance with , care. Review of the LNS Resident log reveals Resident#16 was placed on LNS on for , care. Review of Resident #16's medical record from reveals no documentation of the required monthly LNS nursing assessment for the , care. Review of the facility progress notes in , indicated that Resident #16's	AN278		

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AN278	Continued From page 24 , bag was changed per physician order and skin integrity monitored by nursing staff. 2. Resident #7 was admitted to the facility with medical diagnoses including , , , , , and lower extremity . The resident is assessed as independent for Activities of Daily Living (ADL) care on the current 1823 Resident Assessment form dated . In an interview with Resident #7 on at approximately 11 AM when asked if facility staff were assisting her with applying and removing the , stockings, the resident stated yes, since she was unable to apply the stockings herself. The resident's were observed with no , stockings. Review of the LNS Resident log and electronic medical record reveals Resident#7 was placed on LNS services on for application of , stockings for treatment of lower extremity .. Review of the facility nursing progress notes for Resident #7 revealed nursing staff are documenting the LNS care provided to apply and remove the , stockings as ordered. Further record review for Resident #7 revealed no monthly LNS nursing assessment was completed since . During an interview with the Health & Wellness Director on at approximately 10:00 AM, she confirmed that Residents #7 and #16 were admitted to the facility's LNS care. She stated that the facility aides were emptying Resident #16's , bag and the facility nurses were changing the , bag/ as ordered. She stated that Resident #7 was	AN278		

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AN278	Continued From page 25 receiving daily , stockings care from the facility aides and nursing staff. The Director provided the facility's monthly LNS assessment documentation titled, "Nursing Evaluation" forms for Resident #7 which included forms dated from - . Review of the forms indicated under the skin condition section, the LNS order and specific care requirements. Resident #7's evaluation form indicated , stockings applied to in AM and remove in PM and to check , pulses, document rate, and skin integrity before and after application. The evaluation forms had numerous sections that were left blank and no nursing signature was noted on the forms. Further review of Resident #7's record with the Director revealed the facility nursing staff were documenting stocking application in the AM and removal in PM, there was no documentation of any observation/ monitoring of the skin integrity. Class III	AN278		

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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

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CZ816	Continued From page 1	CZ816		

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

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CZ816	Continued From page 2 s/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 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, it was determined that, the facility did not have a complete Attestation of Compliance Form in file for 1 out of 3 sample Staff (Staff A).	CZ816		

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CZ816	Continued From page 3 The findings included: A review of the personnel file for Staff A (Administrator) revealed he was hired on . Further review revealed the Administrator did not have a complete Attestation form in his employee file. During an interview on at approximately 4:25 PM the Administrator acknowledged the findings. No additional documentation was provided during the survey. Unclassified	CZ816		
ZZ830	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	ZZ830		

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ZZ830	Continued From page 4	ZZ830		

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 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

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ZZ830	Continued From page 5 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 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 timely submit its Comprehensive Emergency Management Plan (CEMP) renewal request to the Local County Emergency Management Division for review and approval. The findings include: On the Administrator provided this surveyor with Entrance Info, Healthcare Survey Binder. A review of the binder revealed a Comprehensive Emergency Management Plan (CEMP) letter dated from the Local County Emergency Management Division dated , with an approval through (copy obtained).	ZZ830		

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ZZ830	Continued From page 6 In an interview with the Administrator on at 11:23 AM he stated the CEMP in the binder (dated) was the most recent and that he has submitted the renewal and is awaiting a response (from the Palm Beach County Emergency Management Division). No additional information or documentation was provided during the survey. Class III	ZZ830		
CZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion.	CZ875		

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CZ875	Continued From page 7 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:	CZ875		

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CZ875	Continued From page 8 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year.	CZ875		

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CZ875	Continued From page 9 (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , must complete the training required in this section before , , . Proof of completion of equivalent training completed before , , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure direct	CZ875		

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CZ875	Continued From page 10 care staff had 's training (within 30 days of hire) for 2 out of 4 sample staff (Staff B and D). The findings included: 1) Review of the personnel file for Staff B (Home Heath Aid) with a hire date of . Staff B did not have documentation of one hour training video from the Department of Elder Affairs (DOEA) within 30 days of being hired in her personnel file. 2)Review of the personnel file for Staff D (Facility Nurse) with a hire date of . Staff D did not have documentation of one hour training video from the Department of Elder Affairs (DOEA) within 30 days of being hired in her personnel file. During an interview on at approximately 4:25 PM the Administrator acknowledged the findings. No additional documentation was provided during the survey. Class III	CZ875		

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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

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CZ816	Continued From page 1	CZ816		

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

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CZ816	Continued From page 2 s/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 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, it was determined that, the facility did not have a complete Attestation of Compliance Form in file for 1 out of 3 sample Staff (Staff A).	CZ816		

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ZZ830	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	ZZ830		

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ZZ830	Continued From page 4	ZZ830		

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 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

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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
ZZ830	Continued From page 5 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 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 timely submit its Comprehensive Emergency Management Plan (CEMP) renewal request to the Local County Emergency Management Division for review and approval. The findings include: On the Administrator provided this surveyor with Entrance Info, Healthcare Survey Binder. A review of the binder revealed a Comprehensive Emergency Management Plan (CEMP) letter dated from the Local County Emergency Management Division dated , with an approval through (copy obtained).	ZZ830		

Agency for Health Care Administration

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	AL11969569	A. BUILDING: _____ B. WING _____	04/15/2025

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ZZ830	Continued From page 6 In an interview with the Administrator on at 11:23 AM he stated the CEMP in the binder (dated) was the most recent and that he has submitted the renewal and is awaiting a response (from the Palm Beach County Emergency Management Division). No additional information or documentation was provided during the survey. Class III	ZZ830		
CZ875	430.5025(4 &) / ; Training (4) Employees of covered providers must complete the following training for 's and related forms of : (a) Upon beginning employment, each employee must receive basic written information about interacting with persons who have 's or related forms of . (b) Within 30 days after beginning employment, each employee who provides personal care to or has regular contact with participants, patients, or residents must complete a 1-hour training program provided by the department. 1. The department shall provide training that is available online at no cost. The 1-hour training program shall contain information on understanding the basics about the most common forms of , how to identify the signs and symptoms of , and skills for communicating and interacting with persons with ' s or related forms of . A record of the completion of the training program must be made available to the covered provider which identifies the training curricula, the name of the employee, and the date of completion.	CZ875		

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CZ875	Continued From page 7 2. A covered provider must maintain a record of the employee's completion of the training program and, upon written request of the employee, provide the employee with a copy of the record of completion consistent with the employer's written policies. 3. An employee who has completed the training required in this subsection is not required to repeat the program upon changing employment to a different covered provider. (c) Within 7 months after beginning employment for a home health agency, nurse registry, or companion or homemaker service provider, each employee who provides personal care must complete 2 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person ' s independence in activities of daily living, and skills in working with families and caregivers. (d) Within 7 months after beginning employment for a nursing home, an assisted living facility, an adult family-care home, or an adult day care center, each employee who provides personal care must complete 3 hours of training in addition to the training required in paragraphs (a) and (b). The additional training must include, but is not limited to, behavior management, promoting the person's independence in activities of daily living, skills in working with families and caregivers, group and individual activities, maintaining an appropriate environment, and ethical issues. (e) For an assisted living facility, adult family-care home, or adult day care center that advertises and provides, or is designated to provide, specialized care for persons with 's or related forms of , in addition to the training specified in paragraphs (a) and (b), employees must receive the following training:	CZ875		

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CZ875	Continued From page 8 1. Within 3 months after beginning employment, each employee who provides personal care to or has regular contact with the residents or participants must complete the additional 3 hours of training as provided in paragraph (d). 2. Within 6 months after beginning employment, each employee who provides personal care must complete an additional 4 hours of -specific training. Such training must include, but is not limited to, understanding and related forms of , the stages of 's , communication strategies, medical information, and stress management. 3. Thereafter, each employee who provides personal care must participate in at least 4 hours of continuing education each calendar year through contact hours, on-the-job training, or electronic learning . For this subparagraph, the term "on-the-job training" means a form of direct coaching in which a facility administrator or his or her designee instructs an employee who provides personal care with guidance, support, or -on experience to help develop and refine the employee's skills for caring for a person with 's or a related form of . The continuing education must cover at least one of the topics included in the -specific training in which the employee has not received previous training in the previous calendar year. The continuing education may be fulfilled and documented in a minimum of one quarter-hour increments through on-the-job training of the employee by a facility administrator or his or her designee or by an electronic learning chosen by the facility administrator. On-the-job training may not account for more than 2 hours of continuing education each calendar year.	CZ875		

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CZ875	Continued From page 9 (f)1. An employee provided, assigned, or referred by a health care services pool must complete the training required in paragraph (c), paragraph (d), or paragraph (e) that is applicable to the covered provider and the position in which the employee will be working. The documentation verifying the completed training and continuing education of the employee, if applicable, must be provided to the covered provider upon request. 2. A health care services pool must verify and maintain documentation as required under s. 400.980(5) before providing, assigning, or referring an employee to a covered provider. (7) For a certified nursing assistant as defined in s. 464.201, training hours completed as required under this section may count toward the total hours of training required to maintain certification as a nursing assistant. (8) For a health care practitioner as defined in s. 456.001, training hours completed as required under this section may count toward the total hours of continuing education required by that practitioner's licensing board. (9) Each person employed, , or referred to provide services before , , , must complete the training required in this section before , , . Proof of completion of equivalent training completed before , , , shall substitute for the training required in subsection (4). Each person employed, , or referred to provide services on or after , , , may complete training using approved curriculum under paragraph (5)(d) until the effective date of the rules adopted by the department under subsection (6). This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure direct	CZ875		

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CZ875	Continued From page 10 care staff had 's training (within 30 days of hire) for 2 out of 4 sample staff (Staff B and D). The findings included: 1) Review of the personnel file for Staff B (Home Heath Aid) with a hire date of . Staff B did not have documentation of one hour training video from the Department of Elder Affairs (DOEA) within 30 days of being hired in her personnel file. 2)Review of the personnel file for Staff D (Facility Nurse) with a hire date of . Staff D did not have documentation of one hour training video from the Department of Elder Affairs (DOEA) within 30 days of being hired in her personnel file. During an interview on at approximately 4:25 PM the Administrator acknowledged the findings. No additional documentation was provided during the survey. Class III	CZ875		