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
	AL11912024	A. BUILDING: _____ B. WING _____	08/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA SERENA I	1200 SW 22 TERRACE MIAMI, FL 33145

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [illegible] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to report the initial employment status within the clearinghouse within 10 business days for one out of 10 staff sampled (Staff F). Findings included:	CZ814		

AHCA Form 3020-0001

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

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CZ814	Continued From page 1 During an interview on . . . . . at 12:06 PM, the administrator stated Staff F was on training. Observation on at 12:11 PM, showed Staff F was inside Resident #3's room by herself, cleaning and organizing. Further observation on . . . . . at 1:25 PM, Staff F served lunch to Residents #8, #10 and #13. Review of background screening database showed that the facility did not list Staff F on the employee roster. During an interview on at 5:05 PM, Staff F stated starting working at the facility on . Unclassified	CZ814		
CZ815 SS=C	408.809; 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or	CZ815		

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CZ815	Continued From page 2 provider who is expected to, or whose responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, ◡ with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or . . . . . ◡ with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee. (3) All ◡ . must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf. (4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an . . . . awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction: (a) Any authorizing statutes, if the offense was a felony. (b) This chapter, if the offense was a felony.	CZ815		

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CZ815	Continued From page 3 (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (h) Section 817.234, relating to false and fraudulent insurance claims. (i) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (j) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (k) Section 817.505, relating to patient brokering. (l) Section 817.568, relating to criminal use of personal identification information. (m) Section 817.60, relating to obtaining a credit card through fraudulent means. (n) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (o) Section 831.01, relating to forgery. (p) Section 831.02, relating to uttering forged instruments. (q) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (r) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (s) Section 831.30, relating to fraud in obtaining medicinal drugs. (t) Section 831.31, relating to the sale, manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony.	CZ815		

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CZ815	Continued From page 4 (u) Section 895.03, relating to racketeering and collection of unlawful debts. (v) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee as of , and was screened and qualified under ss. 435.03 and 435.04, has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) A person who serves as a controlling interest of, is employed by, or contracts with a licensee on , who has been screened and qualified according to standards specified in s. 435.03 or s. 435.04 must be rescreened by , , in compliance with the following schedule. If, upon rescreening, such person has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency within 30 days after receipt of the rescreening	CZ815		

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CZ815	Continued From page 5 results by the person. The rescreening schedule shall be: (a) Individuals for whom the last screening was conducted on or before , must be rescreened by . (b) Individuals for whom the last screening conducted was between , and , must be rescreened by . (c) Individuals for whom the last screening conducted was between , through , must be rescreened by . (6) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (7)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her	CZ815		

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CZ815	Continued From page 6 licensed or certified practice. (8) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining [illegible] pursuant to s. 943.05(2). (9) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any [illegible] person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of	CZ815		

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CZ815	Continued From page 7 employment, the employer may not hire, select, or otherwise allow the employee to have contact with any [redacted] person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been [redacted] for a disqualifying offense, the employer must remove the employee from contact with any [redacted] person that places the employee in a role that requires background screening until the [redacted] is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with [redacted] persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including [redacted] if required, must be disqualified for employment in such position or, if employed, must be dismissed.	CZ815		

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CZ815	Continued From page 8 (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that all staff personnel who have access to client funds, personal property, or living areas had an eligible background screening level 2 for one out of 10 sampled staff (Staff H). Finding included: Observation on at 11:49 AM showed that Staff H walked into the facility. On a further observation on at 12:27 PM Staff H tested the monoxide detector on the living room and at 12:28 PM tested the one on the family room where Residents #5, #6 and #7 sat watching TV. Observation at 12:59 PM showed Staff H searching for gloves and masks supplies in the kitchen drawers and in the cabinets on one the bathrooms.	CZ815		

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CZ815	Continued From page 9 During an interview on at 1:26 PM the administrator stated that Staff H went to the facility least every month. Review of background screening database showed that Staff H completed a background screening level 2 on and the results showed "not eligible". Unclassified	CZ815		

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A 000	Initial Comments AMENDED A COVID-19/Generator monitoring survey was conducted at Villa Serena I on [redacted] and concluded on [redacted]. Deficiencies were identified at the time of survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the	A 025		

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A 025	Continued From page 1 resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain an updated written record of any significant changes for one out of fifteen sampled residents (Resident#11). The facility also failed to contact the health care provider, and legal guardian after one out of fifteen sampled residents had a significant change (Resident#11). Findings include: On at 12:21 PM, during the tour of the facility, the administrator stated that Resident#11 went to the hospital because "she was not feeling quite right." A review of Resident#11's records showed she was admitted on . The health assessment completed on showed medical diagnoses and a history of high , ( ), , , ( ), and . Resident#11 needed	A 025		

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A 025	Continued From page 2 assistance with ambulation, bathing, [illegible], eating, self-care, toileting, transferring, and assistance of self-administration of medications. A review of the facility's hospitalization log showed that the facility sent Resident # 11 to the hospital because she had a [illegible], elevated [illegible] rate, high [illegible], and body aches. Review of Resident#11's progress notes showed no documentation that the facility sent Resident# 11 to the hospital. A review of Resident # 11's record showed no evidence that the facility contacted Resident # 11's healthcare provider or legal guardian when the facility sent Resident # 11 to the hospital. During an interview on [illegible] at 1:32 PM, when asked for the progress notes for Resident # 11, the administrator stated that there were no progress notes updated due to the staff on duty when the resident was in the hospital was out sick. Class III	A 025		
A 030 SS=L	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule	A 030		

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A 030	Continued From page 3 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery	A 030		

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VILLA SERENA I	1200 SW 22 TERRACE MIAMI, FL 33145

(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 030	Continued From page 4 of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity,	A 030		

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A 030	Continued From page 5 individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate	A 030		

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A 030	Continued From page 6 and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care ..., and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ..., the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, ..., and	A 030		

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A 030	Continued From page 7	A 030		

prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and Rights Florida.

429.27 Property and personal affairs of residents.-
(1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs.
(b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or

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A 030	Continued From page 8 dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, record review and interviews, 13 out of 15 residents tested positive for COVID-19 (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13, and #14) after being exposed by three of the facility's caretakers (Staff B, C, and D). The facility failed to protect 14 out of 15 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13, #14 and #15) from exposure to four out of nine staff (Staff B, C, D, and I) who worked with COVID-19 positive cases wearing inadequate Personal Protective Equipment (PPE). The facility failed to place four out nine sampled staff (Staff A, B, I and F) on , for the recommended ten days and continued to allow staff to work and care for residents. The facility's staff who were negative for COVID-19 (Staff A and F) provided care and services to positive and negative COVID-19 residents (14 out of 15 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13, #14 and #15)) . Those staff members did not wear appropriate PPE to prevent cross- . . . . . The facility allowed two out of nine sampled staff with unknown COVID-19 status inside the building and without wearing the appropriate PPE (Staff G and H). Findings included: The COVID-19 is a transmissible	A 030		

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A 030	Continued From page 9 that presents a severe risk to persons who are aged, infirm, or suffer from co- including, but not limited to, system deficiency, , , , and . See generally, Publications of the Centers for Control. On , , the Governor of the State of Florida issued Executive Order 20-51, designating a Public Health Emergency as a result of COVID-19 and its impact. Pursuant to that authority, emergency orders have been issued by the Florida Division of Emergency Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizenry, including those most to the effects of . The Agency for Health Care Administration (AHCA) has issued guidance and clarification on DEM Order 20-006 to providers. On , , issued an alert notifying all homes that all staff or other individuals admitted to a residential facility must don masks and that caregivers must wear gloves when providing resident care. While the treatment and management of residents with and the implementation of isolation precautions for such events are a long-standing health care issues faced by residential facilities, the ease of contagion and the effects of presented by COVID-19 mandate that providers exert meticulous practice and procedure to identify resident symptoms and take immediate , , procedures to both assure appropriate treatment of a potentially resident and protect the remainder of a facility's population from the risk of spread of the . On at 11:40 AM, Staff G and H, both wearing surgical masks and gloves, were	A 030		

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A 030	Continued From page 10 observed exiting their vehicle and walking into the facility. The administrator did not take their temperatures or complete the screening questionnaire. At 12:28 PM, Staff H was observed testing the monoxide detectors in the family room where Resident#5, Resident#6 and Resident# 7 sat watching television. The residents were observed sitting less than 6 apart and not wearing any coverings. In an interview on at 12:09 PM, the Administrator stated that she did not screen the staff due to agency representatives being at the facility. She further stated Staff G was not tested for COVID-19 because the staff did not work at the facility, and that Staff H had given Staff G a ride after Staff G completed her On 4:59 PM, when asked if Staff H had been tested for COVID-19, the administrator stated that yes, he was, and that she would provide the results; however, no documentation of the COVID-19 results for Staff H were provided. On at 11:41 AM, Resident #8 and #10 were observed sitting less than 6 from one another on the front porch without a mask worn. On at 12:00 PM, the administrator stated on [state agency] came and tested the residents but she yet to receive the results. She further stated that she expected some positive results. Review of COVID-19 test results showed that on Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #12, #13, and #14 tested positive to COVID-19. Resident #15 tested negative for COVID-19.	A 030		

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A 030	Continued From page 11 During an interview on at 12:01 PM, the administrator stated it was a challenge to have residents comply with social distancing. At 12:31 PM, the administrator further stated that "each time we give them a mask 2 seconds later, it's on the floor." A review of the residents' progress notes showed no documentation that the facility contacted the residents' medical providers for assistance to have the residents comply with the CDC guidelines. Review of the facility's hospitalization log showed that on Resident#11 was sent to the hospital with a , elevated rate and body aches. On at 1:32 PM, the administrator stated the facility did not document in Resident#11's records she went to the hospital. At 1:38 PM, the administrator stated that Resident#11 went to the hospital because her , was elevated and had body aches but not because of COVID-19. Review of Resident #1's health assessment dated the resident had diagnoses and medical history of , hypercholesteremia, , and essential . Review of Resident #1's COVID-19 test result showed he tested positive on . Review of Resident #2's health assessment dated showed the resident had diagnoses and medical history of , ( ), , ( ), , memory loss and .	A 030		

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A 030	Continued From page 12 Review of Resident #2's COVID-19 test result showed he tested positive on . Review of Resident #3's health assessment dated showed the resident had diagnoses and medical history of unspecified of and . Review of Resident #3's COVID-19 test result showed he tested positive on . Review of Resident #4's health assessment dated the resident had diagnoses and medical history of high ( ) and , lipase (HL). Review of Resident #4's COVID-19 test result showed he tested positive on . Review of Resident #5's health assessment dated the resident had diagnoses and medical history of , injury, , high ( ). Review of Resident #5's COVID-19 test result showed he tested positive on . Review of Resident #6's health assessment dated the resident had diagnoses and medical history of ( ) , high , ( ), ( ) and . Review of Resident #6's COVID-19 test result showed he tested positive on . Review of Resident #7's health assessment dated the resident had diagnoses and medical history of high ( ), iron deficiency (IDA), , , ( ), and . Review of Resident #7's COVID-19 test result showed he tested positive on .	A 030		

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A 030	Continued From page 13 Review of Resident #8's health assessment dated had diagnoses and medical history of and . Review of Resident #8's COVID-19 test result showed he tested positive on . Review of Resident #9's health assessment dated the resident had diagnoses and medical history of , high , ( ), , (ETOH), . Review of Resident #9's COVID-19 test result showed he tested positive on . Review of Resident #10's health assessment dated the resident had diagnoses and medical history of , , ( ), deficiency, (HLD), and ( ). Review of Resident #10's COVID-19 test result showed he tested positive on . Review of Resident #11's health assessment dated had diagnoses and medical history of high , ( ), ( ), and . Review of Resident #12's health assessment dated had diagnoses and medical history of high , ( ), type 2, ( ), and . Review of Resident #12's COVID-19 test result showed he tested positive on . Review of Resident #13's health assessment dated had diagnoses and medical history of 's , ,	A 030		

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A 030	Continued From page 14 and . Review of Resident #13's COVID-19 test result showed he tested positive on . Review of independent living Resident #14's health assessment dated had diagnoses and medical history of , , (O/A), ( ), and type 2. Review of Resident #14's COVID-19 test result showed he tested positive on . Review of independent living Resident #15's health assessment dated had a diagnoses and medical history of high ( ), (O/A), and hypocomplementemia. Review of Resident #15's COVID-19 test result showed he tested negative on . Observation on at 12:27 PM showed that Residents #2, #3, #4, and #15 occupied bedrooms on the second floor. Further observation showed the only bathroom on the second floor was not stocked with soap or paper towels to facilitate adequate hygiene. On at 12:27 PM, during the tour of the facility, the administrator stated that all the residents that occupy the second floor share the bathroom on that floor. On at 12:39 PM, observed the visiting Home Health Nurse wearing a surgical mask and gloves enter the facility and walk to Resident# 12's room. During an interview at 12:40 PM, the home health nurse stated the agency sent her to administer Resident#12's . A review of Resident #12's COVID-19 test results showed	A 030		

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A 030	Continued From page 15 that the resident was positive. A review of recommendations from the Centers for Control (CDC) dated showed that if COVID-19 was suspected or identified in a resident of an Assisted Living Facility, the residents should immediately be in their room and the health department notified. The recommendations further stated that "For situations where close contact between any (, or ,) resident cannot be , personnel should at a minimum, wear protection (goggles or shield) and an N95 or higher-level , (or a facemask if are not available or personnel are not fit-tested)." The recommendations stated that if personnel have direct contact with the resident, they should also wear gloves. If available, gowns are also recommended but should be prioritized for activities where splashes or sprays are , or high-contact resident-care activities that provide opportunities for transfer to , to and clothing of personnel (e.g., , bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting. On at 3:31 PM, during the facility tour, Staff F was observed walking into multiple resident rooms sweeping the floor while wearing a cloth mask. Review of recommendations from the CDC show that cloth coverings are NOT PPE and should not be worn for the care of patients with suspected or confirmed COVID-19 or other situations where use of a , or facemask is recommended. The recommendations further state facemasks are preferred over cloth	A 030		

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A 030	Continued From page 16 coverings for healthcare personnel as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of . . material from others. Further observation at 4:01 PM, showed Resident#1 pass Staff F the telephone and state that Staff A wanted to talk to her. Observed Resident#1 was not wearing a mask. Review of Resident#1's test results show that she tested positive for COVID-19 on . . . . . . On . . . . . at 1:30 PM, the administrator stated she hired new staff, Staff F, to relieve positive staff. On . . . . . at 5:09 PM, during a phone interview, Staff F stated that Staff I trained and worked alongside her caring for residents at the facility the week of . A review of staff test results show that Staff I tested positive for COVID-19 on . Review of recommendations from the CDC show that healthcare personnel who had prolonged close contact with a healthcare personnel confirmed with COVID-19 should be excluded from work 14 days after last exposure. A review of the facility's record showed no documentation that the home health agency nurses were tested for COVID-19. On at 12:47 PM, the administrator stated that she had no documentation of the home health agency staffs' test results. On at 12:55 PM, when asked about the amount of Personal Protective Equipment (PPE) in stock at the facility, the administrator	A 030		

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A 030	Continued From page 17 stated she did not know. She further stated she would have to call the house manager to get the information. Observation on at 12:56 PM, observed the administrator presented a box of 100 count gloves and a 60 oz bottle of sanitizer. Further observation at 12:58 PM, showed the administrator called out to the Staff H, the maintenance person, to assist her in finding the PPE. Then observed Staff H open a drawer in the kitchen and pulled out two packages of 25 count surgical masks. Observed that the facility did not have any shields, N95 masks, or gowns in stock during the onsite inspection. In an interview on at 1:40 PM, the administrator stated that the facility cooked and served meals for the independent residents and that all residents, including the independent residents, ate in the common dining area. The administrator added that the residents required assistance or supervision with the activities of daily living, and that all residents at the facility needed assistance with self-administration of medications. Class I	A 030		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their	A 055		

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A 055	Continued From page 18 possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is	A 055		

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A 055	Continued From page 19 located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing	A 055		

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A 055	Continued From page 20 pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to keep medications locked at all times. Findings included: Observation on . . . . . at 12:25 PM showed that there was a medication cabinet on the living room. The medication cabinet had an opened lock. Residents #8 and #10 sat on the front porch which was next to the living room. Review of Resident #8's record showed that according the health assessment (AHCA form 1823), the resident needed supervision with ambulation and transferring and with assistance with self-administration of medications. Review of Resident #10's record showed that according the health assessment (AHCA form 1823), the resident needed assistance with ambulation, transferring and self-administration of medications. During an interview on . . . . . at 12:27 PM, the administrator stated she left the medication cabinet opened. Class III	A 055		
A 077 SS=G	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10	A 077		

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A 077	Continued From page 21 days and provide documentation within 90 days that the new administrator has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A new facility administrator must complete the required training and education, including the competency test, within 90 days after date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least [illegible]; 2. If employed on or after [illegible], have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background	A 077		

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A 077	Continued From page 22 screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and, 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three	A 077		

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A 077	Continued From page 23 assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to have an administrator capable of handling the operation and maintenance of the facility, including the management of all staff and residents (Staff A). The administrator failed to screen non-essential staff who walked in the facility. The administrator failed to know the names of the residents admitted to the facility while with staff in training on duty. The	A 077		

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A 077	Continued From page 24 administrator failed to prohibit staff who have not been tested for COVID-19 from entering the facility. The administrator failed to ensure staff wore appropriate Personal Protective Equipment (PPE) when caring for suspected or confirmed COVID-19 residents. The administrator failed to have knowledge of the location of PPE onsite during the COVID-19 pandemic. Findings include: A review of the background screening database showed that Staff A was the facility's administrator since . On at 11:40 AM, observation showed the administrator allowed Staff G and H into the facility without taking their temperatures nor completing the screening questionnaire. In an interview with the administrator on at 12:17 PM, she stated that she did not screen the staff due to agency representatives being at the facility. Observation on at 11:41 AM, showed Resident#8 and Resident#10 sitting on the front porch. Further observation at 11:42, showed the administrator asking the residents their names. At 12:16 PM, during the facility tour, observed Resident#5, Resident#6, and Resident#7 sitting in the living room area watching television. In an interview with the administrator on at 12:16 PM, the administrator stated that she did not know the names of the residents and would have to ask them their names. On at 12:17 PM, observation showed the administrator walking to Resident#5,	A 077		

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A 077	Continued From page 25 Resident#6, and Resident#7 and asking them their names. On at12:16 PM, during the facility, the administrator stated that Resident#14 shared a room with Resident#5. At 12:19 PM, the administrator then stated that Resident#14 shared the room with Resident#11. Observation on at 12:39 PM, showed Staff J enter the facility. Staff J was observed wearing surgical mask and gloves. In an interview on at 12:39, Staff J stated she was a home health agency nurse providing services to Resident#12. On at 12:47 PM, the administrator stated she did not have the documentation of COVID-19 test results for Staff J. Observation on at 11:50 AM, showed the administrator cleaning the facility. On at 12:11 PM, Staff F was observed cleaning residents' rooms. At 1:25 PM, Staff F was also observed preparing and serving lunch to Resident#8, Resident#10 and Resident#13. Both staff members were observed wearing surgical masks and gloves. In an interview with the administrator on at 12:00 PM, the administrator stated that residents were tested for COVID-19 on and she expected some of the residents to be positive. Interview on . . . . . at 12:55 PM, the administrator stated she did not know the amount and location of the Personal Protective Equipment (PPE) onsite.	A 077		

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A 077	Continued From page 26 Observation on at 12:58 PM, showed the administrator call out to the Staff H, the maintenance person to assist her in finding the PPE. Then observed the Staff H open a drawer in the kitchen and pull out 2 packages of 25 count surgical masks. Class II	A 077		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 . . 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for	A 079		

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A 079	Continued From page 27 purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and , , ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least , , must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the	A 079		

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A 079	Continued From page 28 minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility	A 079		

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A 079	Continued From page 29 administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, record review and	A 079		

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A 079	Continued From page 30 interview, the facility failed to maintain a written work schedule that reflects its 24-hour staffing pattern. Findings included: Observation on . . . . . at 11:50 AM, showed the administrator mopping the floor of the living room. During an interview on . . . . . at 12:06 PM, the administrator stated being on duty 24 hours, every day for the last three days. Staff F was on training. Observation on at 12:11 PM, showed Staff F was inside Resident #3's room, cleaning and organizing. Further observation on at 1:25 PM, Staff F served lunch to Residents #8, #10 and #13. Review of the written staff work schedules showed they covered from . . . . . to . . . . . , from to and from to . . . . . . There was no current staff schedule reflecting the 24-hour staffing pattern for the current week from . . . . . to . . . . . . During an interview on . . . . . at 12:57 PM, the administrator stated, "I haven't changed the schedule yet." Class III	A 079		
A 193 SS=D	59AER20-4 Mandatory Testing for Assisted Living Facilit (1) APPLICABILITY. The requirements of this emergency rule apply to all assisted living	A 193		

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A 193	Continued From page 31 facilities licensed under Chapter 429, F.S. (2) DEFINITIONS. "Staff" means all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or materials, including body substances (e.g., , tissue, and specific ,); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. Staff may include, but are not limited to, nurses, nursing assistants, physicians, technicians, , , , , pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons (e.g., clerical, dietary, environmental services, laundry, security, maintenance, engineering and facilities management, administrative, billing, and volunteer personnel) not directly involved in patient care but potentially exposed to agents that can be transmitted among from staff and patients. This definition is consistent with the Centers for Control and Prevention definition of Healthcare personnel as defined in Appendix 2. . (3) MANDATORY STAFF TESTING FOR COVID-19. (a) Beginning , , assisted living facilities shall not admit into the facility any staff who has not been tested for COVID-19. (b) Assisted living facilities shall require all staff be tested every two (2) weeks thereafter with testing resources provided by the state. (4) EXEMPTION FROM TESTING. Staff who have already been and recovered from COVID-19 do not need to be tested if they can provide medical documentation to the assisted living facility. (5) DOCUMENTATION.	A 193		

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A 193	Continued From page 32 (a) If testing is conducted off-site, then staff must provide proof of testing to the assisted living facility. (b) Assisted living facilities shall document all staff testing, including the name of the individual, time, and date of the test. (c) Assisted living facilities shall require all tested staff to notify the facility of the test results the same day the results are received. Written documentation of test results must be provided to the facility upon receipt by the staff. (d) Assisted living facilities shall keep copies of all staff testing documentation on site. (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency may seek any remedy authorized by Chapter 429, Part I, or Chapter 408, Part II, F.S., including but not limited to, license revocation, license suspension, and the imposition of administrative fines. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to prohibit staff not tested for COVID-19 from entering the facility (Staff G, H, J). The facility also failed to provide the testing results or documentation that staff that have been tested for COVID-19 (Staff G, H, J). Findings include: Observation on at 11:40 AM, showed the administrator allowed Staff G and Staff H into the facility. Review of the facility's record showed that there was no evidence indicating that Staff G and Staff H were tested for COVID-19. On at 4:59 PM, the administrator	A 193		

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	AL11912024	A. BUILDING: _____ B. WING _____	08/05/2020

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A 193	Continued From page 33 stated that Staff H was tested for COVID-19. Observation on . . . . . at 12:39 PM, showed Resident#12's home health nurse, Staff J enter the facility and walk to Resident#12's room to provide care. During an interview on at 12:39 PM, Staff J stated she was sent by the home health agency to provide nursing services to Resident#12. Review of facility's record showed that the facility did not have documented evidence that Staff J or any other home health agencies' nurses were tested for COVID-19. In an interview with the administrator on . . . . . at 12:47 PM, she stated that she did not have documentation of the test results. Class III	A 193		
A 200 SS=D	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current	A 200		

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A 200	Continued From page 34 licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care	A 200		

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A 200	Continued From page 35 offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain	A 200		

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A 200	Continued From page 36 temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . . monoxide alarm. (2) SUBMISSION OF THE PLAN.	A 200		

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A 200	Continued From page 37 (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post	A 200		

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A 200	Continued From page 38 the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation. (4) IMPLEMENTATION OF THE PLAN. (a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than , have implemented the plan required under this rule. (b) The Agency shall allow an extension up to to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S. (c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours. 1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place	A 200		

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A 200	Continued From page 39 for delivery of an alternative power source and fuel when requested. Within twenty-four (24) hours of the issuance of a state of emergency for an event that may impact primary power delivery for the area of the assisted living facility, it must have the alternative power source and no less than ninety-six (96) hours of fuel stored onsite. 2. An assisted living facility located in an evacuation zone pursuant to chapter 252, F.S. must either: a. Fully and safely evacuate its residents prior to the arrival of the event; or b. Have an alternative power source and no less than ninety-six (96) hours of fuel stored onsite, within twenty-four (24) hours of the issuance of a state of emergency for the area of the assisted living facility. (d) Each new assisted living facility shall implement the plan required under this rule prior to obtaining a license. (e) Existing assisted living facilities that undergo any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of the systems or equipment affecting the assisted living facility's compliance with this rule shall implement its amended plan concurrent with any such additions, modifications, alterations, refurbishment, renovations or reconstruction. (f) The Agency for Health Care Administration may request cooperation from the State Fire Marshal to conduct inspections to ensure implementation of the plan in compliance with this rule. (5) POLICIES AND PROCEDURES. (a) Each assisted living facility shall develop and implement written policies and procedures to ensure that the assisted living facility can effectively and immediately activate, operate and	A 200		

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A 200	Continued From page 40 maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law.	A 200		

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A 200	Continued From page 41 (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format,	A 200		

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A 200	Continued From page 42 upon request. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to test the generator to ensure it functioned to safely and sufficiently operate the alternate power source maintained at the assisted living facility. Findings included: Review of facility's record showed that the facility did not keep a generator/emergency environmental equipment maintenance log. During an interview on at 1:26 PM the administrator stated that Staff H tested the generator at least every month. During an interview on at 1:27 PM Staff H stated he kept the generator log at the main office. Class III	A 200		