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
	AL11963757	A. BUILDING: _____ B. WING _____	09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA VILLA	5151 S.W. 61 AVENUE DAVIE, FL 33314

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A 000	Initial Comments An unannounced licensure Complaint survey, #2020014917, and . . . . Control Survey were conducted on and at Victoria Villa, Inc. The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A , ill resident who no longer meets	A 010		

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A 010	Continued From page 1 the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care	A 010		

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A 010	Continued From page 2	A 010		

provider, the resident must be discharged from the facility.
(c) A [redacted], ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met:
1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;
2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;
3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,
4. Documentation of the requirements of this paragraph is maintained in the resident's file.
(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.
(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.
(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.
(g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.

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A 010	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on observation and record review, the facility failed to ensure that Resident Health Assessment (AHCA form 1823) were completed through a -to- examination by a healthcare provider, for 11 out of 11 residents. As evidence of Resident #1 - #11's Health Assessment forms completed without . . . - to- examination by a Healthcare Provider that was not the resident's primary care Provider. The Findings Include: During interview with the Administrator on and , during the hours of 9 AM and 6 PM; the criteria for completion of Resident Health Assessment were discussed .As part of the continued residency criteria, a resident must have a -to- medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. The results of the examination must be recorded on AHCA Form 1823. During the Survey on and , a request was made for Resident Records. The Administrator stated the records were locked and the Office Manager had quit, and she didn't have the key. As such the records were not provided to the surveyor upon request and no record review could be conducted for Resident #1-#11. On at 7:48 PM, this Surveyor was in the office located to the left immediately upon entering the main building and observed the facility's Podiatrist sitting in the chair behind the desk completing Resident Health Assessment	A 010		

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A 010	Continued From page 4	A 010		

forms (AHCa 1823). The Administrator was standing by the door, Staff B was in the Nurses Station with the Hospice Nurse making copies and preparing Resident information to send to the COVID-19 facility.

At 6:00 PM, this Surveyor observed a Transportation Vehicle arrive at the facility. The vehicle left the facility at 6:33 PM with Residents (Residents 2, 3, and 5). The Administrator and the Podiatrist were not at the facility at the time of departure. No -to- assessment was conducted for these residents. However, Resident Health Assessment forms were completed by the facility's Podiatrist upon her return to the facility. The Podiatrist was heard by this Surveyor stating, she knows all the residents.

On . . . . . at 6:12 PM, this Surveyor observed a medical transport vehicle arrive at the facility. This Surveyor observed the vehicle leave the facility at 6:33 PM carrying Resident #4. The Administrator and the facility's Podiatrist were not at the facility at the time of the transport. No . . . -to- . . . assessment was completed. However, this Surveyor observed the facility's Podiatrist completing AHCA form 1823 for the Resident.

On at 7:04 PM, Resident #11 was observed by this Surveyor being transported from the facility by (Medical Transportation vehicle). This Surveyor did not observe the resident receive a -to- examination by the Podiatrist or any medical personnel. However, an AHCA form 1823 was observed being completed by the facility's Podiatrist.

On at 7:36 PM Resident #10 was observed by this Surveyor being transported from

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A 010	Continued From page 5 the facility by (Medical Transportation vehicle). This Surveyor did not observe the resident receiving a . . . -to- . . . examination by the Podiatrist or any medical personnel. However, an AHCA form 1823 was observed being completed by the facility's Podiatrist. On at 7:52 PM, Resident #6 was observed by this Surveyor being transported from the facility by (Medical Transportation vehicle). This Surveyor did not observe the resident receiving a -to- examination by the Podiatrist or any medical personnel. However, an AHCA form 1823 was observed being completed by the facility's Podiatrist. During Exit Interview conducted via telephone on with the Administrator, Nursing Supervisor, facility Podiatrist, Survey team and Area Supervisor. This Surveyor advised that Resident 1823's are required to be completed utilizing a -to- method. And that observation revealed that they were not completed as required. Class III	A 010		
A 077 SS=D	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 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	A 077		

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A 077	Continued From page 6 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 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	A 077		

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A 077	Continued From page 7 becoming employed as a facility administrator. Administrators who attended core training prior to [redacted], 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 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.	A 077		

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A 077	Continued From page 8 (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 Administrator failed to provide supervision related to the operations and maintenance of the facility, staff and the provision of appropriate care for 11 out of 11 sampled residents (Resident #1- #11). The Findings Include: a) On , Staff F repeated identified herself as the Administrator of the facility. However, after further interviews with the Owner; she identified Staff F as a family friend, that came to visit her at the facility and seeking a job at the	A 077		

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A 077	Continued From page 9 facility (as the Administrator. However, the Owner identified herself as the Administrator and allowed the surveyors to interact with Staff F and at no time tried to correct this until . The Administrator/Owner confirmed that Staff F was not screened upon arrival or at any time during the visit and was not . . . . . / , ... for 14 days prior to entering the facility per CDC guidance updated . . . . . . b) During a tour of the facility, on . . . . . beginning at 12:10 PM, accompanied by the Administrator/Owner, it was noted that there were 5 'kits' in the corridor that contained gowns, gloves and a bottle of . . . sanitizer (ABHR). When the Administrator/Owner was asked about the facility's protocol for PPE use on the unit and in the residents' rooms, she replied, "what is PPE?" After this surveyor explained the definition of PPE, based on CDC guidance updated . . . . . , the Administrator/Owner stated that all staff are to be in full PPE (mask, gown gloves and . . . shield). For the duration of the tour, the Administrator, with a bird on her , was observed entering residents' rooms without donning any PPE, with the exception of the mask and gloves that she was already wearing and wore from room to room, despite this surveyor's encouragement to don PPE per protocols. Staff were observed wearing garbage bags over the gowns, Administrator/Owner stated that it was a recommendation that DOH made during their visit on . It was noted that the garbage bags that were being used only covered the upper torso to approximately the waste of the staff and not did not cover any portion of the arms. When Staff A and Staff C were asked where they dispose of used PPE, both replied that they discard it in the waste receptacle inside	A 077		

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A 077	Continued From page 10 of the residents' rooms. Staff A opened one of the doors to a resident's room and pointed to a small waste receptacle that was used for all garbage/waste from the residents' rooms and did not have a lid and was not designated as a receptacle for or biohazard waste. c) On at 10:01 AM, during an interview with the Administrator, this Surveyor requested information regarding staff and resident COVID-19 testing. She stated she did not know and that her office manager quit and didn't give her anything. She also stated that her nurse was out. She stated, "Maybe (name of Hospice Nurse) will know."When asked about reporting via ESS (Emergency Status System), the Administrator/Owner, the LPN Supervisor and Staff F stated that they had no knowledge of the ESS reporting requirements and could not provide any information related to reporting resident findings to local health department(s) On at 10:23 AM, this Surveyor asked her about the facilities Control protocols. She responded by stating her nurse was out since yesterday, the Office Manager left a long time ago and she didn't tell me what was going on. She continued to defer responsibility and blamed everything on the Office Manager. This Surveyor reminded her that she is the Administrator and the operations of facilities upon the person in that position. This Surveyor asked if she knew how to reach out to other entities (County, State) for possible Control training related COVID-19 for staff. She said she did not. The Administrator was further questioned regarding the facility's control policy & procedures	A 077		

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A 077	Continued From page 11 handbook/documentation. The Administrator stated, they have one but don't know where the Office Manager put it. The Administrator failed to ensure that she had access to the facility's policies and procedures and could provide them as may be required. Nor could she verify that staff was aware of them, and if staff had received training related to COVID-19. On at 11:37 AM, the Administrator, was asked if any resident(s) were showing signs and symptoms of the . She said "no". She was informed that he was informed by a staff member that Resident 12 is exhibiting symptoms. She stated she was not aware of it and that no one tells her anything. On at 12:13 PM, the Surveyors requested from the Administrator information regarding their last Curative test. She stated, she wasn't sure and went to look. She returned to the room where the Surveyors were working with nothing. On . . . . . at 12:29 PM, the Hospice Nurse came into the office where Surveyors were working. She stated all the staff and residents were tested on and that she remembered seeing everyone getting swabbed. This Surveyor asked the Administrator, if she was aware of the testing and had the results and couldn't provide any information. On at 2:10 PM, the Administrator and Hospice Nurse came into the room where the Surveyors were working and stated that they just got the results, all the remaining residents tested positive. This Surveyor asked the Administrator if she was designating the Hospice Nurse to act on behalf of the facility and she said yes. The	A 077		

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A 077	Continued From page 12 information provided was for all eleven (11) residents. The Administrator failed to ensure that a non-employee of the facility did not have access to medical information on Residents not within their care. d) Throughout the course of the Survey (and), from entry at 9:05 AM until the arrival of the facility's Podiatrist, the Hospice Nurse, who is not an employee of the facility, acted in the capacity of the facility's Nurse, Administrator/or Manager. The Hospice Nurse opened the door to allow the Survey Team entry and took their temperatures. The Hospice Nurse was also observed throughout the Survey assisting staff in a capacity beyond providing medical care to her five (5) Hospice patients. In addition, this Surveyor observed the Administrator on several occasion during the Survey on defer facility responsibilities to the Hospice Nurse. On at 3:49 PM this Surveyor attempted to interview the Administrator who was in the hall near her office with a gentleman and a female in scrubs. This Surveyor asked to speak with the Administrator and the female stated I could. This Surveyor advised that I needed to speak with only the Administrator, unless the Administrator authorized me to speak with her. The administrator directed this Surveyor to speak with the female who was standing by her and we went into the office located by the front door. This Surveyor asked for her identity of the female in scrubs and she stated her name was (name), the podiatrist for the facility. "I'm also her attorney." This Surveyor explained to the Administrator the that the previous arrangements were completed (for the transfer of Resident to a	A 077		

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A 077	Continued From page 13 COVID-19 facility) and now they are not. She responded that she doesn't know what happened. This Surveyor reminded her that she is the Administrator and the person to whom should know what's going on. She continued to divert the responsibility to other employees. The facility's Podiatrist acknowledged, that this Surveyor was correct and that she would speak on her behalf. She asked the Administrator what happened. She stated she didn't know, (Staff B) was making the arrangements. On at 4:28 PM, Surveyor A was handed a cell phone by the Hospice Nurse with a family member on the other end was inquiring about a family member's transfer to the COVID-19 facility. The Administrator and Podiatrist came into the room. This Surveyor requested that the Administrator speak with the caller as the facility was in charge of coordination. The Podiatrist (who is not an employee of the facility) took the cell phone and explained to the caller that all the Residents are going to (facility) for about 10-days and will be returning. The Administrator did not speak with the caller. The Podiatrist was also observed by this Surveyor directing staff as the Administrator was primarily non-involved. e) Once, the Administrator identified all persons that tested positive on , she informed the surveyors that her policy is to transfer all positive residents to a Covid facility. The facility will not house positive residents, no way to them per the Administrator. However, repeatedly throughout the day, the Administrator failed to perform her duties as the Administrator to coordinate and expedite the transfer of the residents to prevent further spread within the	A 077		

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A 077	Continued From page 14 facility as it relates to other staff members and survey team. As evidence of the Administrator failing to contact the COVID facilities timely, prepare documents and other related tasks. The residents were not able to safely be transferred out until after 8:30 PM on due to the delay of the Administrator duties. When preparations were attempted early in the day under the assistance of the surveyors , which would have allowed the transport of the residents earlier in the afternoon. As the COVID facility confirmed earlier in the day that they had space to take all of the residents. However, the Administrator halted the process, no explanation provided. The AHCA Field Office Manager (FOM) and the ALF Supervisor were contacted by the surveyors around 3 PM on regarding the delay and the lack of cooperation of transfer by the Administrator. The FOM spoke with the Administrator and the Podiatrist (the parties). At this time, the FOM discussed the circumstances with the parties. After the discussion, the parties agreed to restart the relocation process of the residents again and confirmed all residents would be transferred out today. On at 8:17 PM, the Survey team met with the Administrator and the facility's Podiatrist to advise that the Exit Interview would not be conducted today as patients were still being transitioned from the facility and it would be scheduled for next week. They understood and agreed. On an Exit Interview was conducted via telephone with the Administrator, Nursing Supervisor, facility Podiatrist, Survey team and Area Supervisor, this Surveyor this Surveyor restated to that the Administrator was observed to have failed to provide the required Supervision	A 077		

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A 077	Continued From page 15 relative to operations of the facility and care of residents. The facility's Podiatrist acting on her behalf acknowledged the findings. Class III	A 077		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of . . . . . testing materials satisfies the annual . . . . examination requirement. An individual with a positive . . . . . test must submit a health care provider's statement that the individual does not constitute a risk of 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	A 078		

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A 078	Continued From page 16 (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility _____ to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. 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 1 out of 1 employees (Administrator) had their Freedom from statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable	A 078		

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A 078	Continued From page 17 . . . . . updated annually. The Findings include: On . . . . . an . . . . . Control Survey was conducted at the facility. During the Survey this Surveyor requested the Administrator's facility file. Review of the Administrator's facility file on . . . . . revealed that it did not contain a current ( ) statement. The Administrator was provided an opportunity to review the file and did not. On at 8:17 PM the Survey team met with the Administrator and facility Podiatrist to advise that the Exit Interview would not be conducted today as patients were still being transitioned from the facility and it would be scheduled for next week. They understood and agreed. During Exit Interview conducted via telephone on . . . . . with the Administrator, Nursing Supervisor, facility Podiatrist, Survey team and Area Supervisor, this Surveyor this Surveyor restated that the Administrator did not have a current . . . . . ( ) statement in her file. They were also advised that verification of status is required annually, and that the most recent documentation in the file was dated . . . . . . Class III	A 078		
A 164 SS=D	59A-36.015(4) FAC; 429.35(1) & (3) FS Records - Inspection Availability 59A-36.015(4) RECORD INSPECTION. (a) The resident's records must be available to	A 164		

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A 164	Continued From page 18 the resident; the resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; or the resident's estate, and such additional parties as authorized in writing or by law. (b) Pursuant to section 429.35, F.S., agency reports that pertain to any agency survey, inspection, or monitoring visit must be available to the residents and the public. In facilities that are co-located with a licensed nursing home, the inspection of record for all common areas is the nursing home inspection report. 429.35 Maintenance of records; reports.- (1) Every facility shall maintain, as public information available for public inspection under such conditions as the agency shall prescribe, records containing copies of all inspection reports pertaining to the facility that have been issued by the agency to the facility. Copies of inspection reports shall be retained in the records for 5 years from the date the reports are filed or issued. (3) Every facility shall post a copy of the last inspection report of the agency for that facility in a prominent location within the facility so as to be accessible to all residents and to the public. Upon request, the facility shall also provide a copy of the report to any resident of the facility or to an applicant for admission to the facility. This Statute or Rule is not met as evidenced by: Based on interview and lack of records to review, the facilty failed to have pertinent records available to the survey team in a timely manner. The findings included: During the entrance conference on [redacted], beginning at 9:25 AM, with the	A 164		

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A 164	Continued From page 19 Administrator/Owner, Staff F and the LPN Supervisor, when asked for a resident census and a staff roster, the Administrator/Owner stated that there was no access to the information requested due to the Office Manager not being available to provide. Then, the Administrator/owner stated the Office Manager was responsible for maintaining the information requested and that she had left the facility 10 days prior to the visit due to a in the family, and had no contact with her since then ( ). When asked how residents were monitored for signs or symptoms of COVID 19, the Administrator/Owner replied that residents were monitored Q shift (every shift) with temperature. she further stated that when staff report new onset of symptoms, the nurse will do an assessment for anything that was "out of the norm". This surveyor requested to review the spreadsheet where findings are documented, this surveyor was directed to a spiral notebook that was on a medication cart, with temperature documented and new symptoms documented. When this surveyor requested to review the residents' records, the Administrator again replied that she did not have access to the residents' records due to the absence of the Office Manager. When Staff A was asked how residents were monitored, she replied that residents area screened every day via temperature and staff report temperatures the supervisor and docment in a spreadsheet. On at 7:25 PM, this surveyor was	A 164		

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A 164	Continued From page 20 provided demographic sheets for the residents as requested, from Staff B. This was the first resident record that was provided to the survey team during the two day survey, after requesting since the entrance conference on ..... at 9:25 AM Class III	A 164		

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CZ815 SS=D	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 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	CZ815		

AHCA Form 3020-0001

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

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CZ815	Continued From page 1 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. (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	CZ815		

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CZ815	Continued From page 2 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. (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 and was screened and qualified under s. 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.	CZ815		

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CZ815	Continued From page 3 (5) 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. (6)(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 licensed or certified practice. (7) 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 , pursuant to s. 943.05(2). (8) 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	CZ815		

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CZ815	Continued From page 4 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 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 employment, the employer may not hire, select, or otherwise allow the employee to have contact with any 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 for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires	CZ815		

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CZ815	Continued From page 5 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. (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 [redacted] for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was [redacted], 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:	CZ815		

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CZ815	Continued From page 6 (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 interview, observation and record review, the facility failed to maintain background clearinghouse roster for all staff, for 2 out of 2 sampled personnel . The findings included: 1) During a review of the facility's roster in the background screening clearinghouse, on . . . . . at 5:15 PM, it was noted that Staff G, who is responsible for assisting in maintaining the facility, grounds and caring for the animals (cats inside and outside of the facility) in and outside of the facility was not on the roster. The Administrator/Owner and the Podiatrist confirmed that Staff G was an employee of the facility. Staff G was observed multiple times throughout the two days of the survey entering the facility into the reception/lobby area as well as in a common area where Resident #1 . . . . . and a second common area where Resident #11 frequently left her room and was found on multiple occasions 2). During a review of the facility's roster in the background screening clearinghouse, on . . . . . at 5:15 PM, it was discovered that the Chef had been declared 'Not Eligible' as of . . . . The Chef was observed multiple times throughout the two-day survey exiting the kitchen into a common area that was adjacent to the reception/lobby area where Resident #1 frequently . . . . . and was found.	CZ815		

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
	AL11963757	A. BUILDING: _____ B. WING _____	09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA VILLA	5151 S.W. 61 AVENUE DAVIE, FL 33314

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CZ815	Continued From page 7 Unclassified	CZ815		