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
	AL11969127	A. BUILDING: _____ B. WING _____	12/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANTHEM LAKES, LLC	905 ASSISI LN JACKSONVILLE, FL 32223

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A 000	Initial Comments A complaint survey (complaint number 2020017314) was conducted at Anthem Lakes, LLC from to . Deficient practice was identified at the time of the survey.	A 000		
A 030	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 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.	A 030		

AHCA Form 3020-0001

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

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A 030	Continued From page 1 (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 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	A 030		

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A 030	Continued From page 2 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, 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	A 030		

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A 030	Continued From page 3 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 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 must be set forth in writing and	A 030		

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A 030	Continued From page 4	A 030		

provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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 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

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A 030	Continued From page 5 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 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 interview, record review, and observation, the facility failed to ensure the safety and wellbeing of their residents by failing to follow current CDC guidance related to COVID-19 control procedures. This has the potential to place all residents at risk of exposure. The findings include:	A 030		

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A 030	Continued From page 6 1. On at 9:00 am, upon entrance into the facility, Staff F was observed working the receptionist desk without a mask. Residents were seen, along with other staff members, walking near the reception area and in the presence of Staff F. When the Surveyor identified herself, Staff F eventually put on her mask. At 10:20 am on , the Administrator explained staff were required to wear a mask while on duty. Residents were not encouraged to wear masks. They can if they choose to, and they have a few residents that do wear them. On 12:44 pm Staff G was observed sitting at the front receptionist desk. Staff G was asked if this was his lunch break. Staff G stated no. He was asked why he was not wearing his mask. Staff G picked up his mask, put it on, and said, "Now, I have it on!" Staff G was unable to explain why his mask was not on. Staff G was also observed without his mask on while serving residents at the receptionist desk at 1:32 pm and 2:30 pm on . On at 2:17 pm, Resident #12 stated he often sees staff not wearing their masks while in the facility. On at 8:45 am, upon entrance to the facility, the Administrator was observed walking in the area of the Receptionist desk without a mask. She was speaking to staff without the mask on. Residents were observed in the area who also were also not wearing masks. In an interview conducted with the Administrator	A 030		

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A 030	Continued From page 7 on . . . . . at 4:15 pm, when asked why is some staff members, herself included, were permitted to walk around the facility without a . . . mask. The Administrator did not provide a response. 2. On , the Agency released a memo titled "Long-term care and Residential Facility Notification Requirement Reminder." It detailed that "it is critical that facilities with positive COVID-19 cases continue to notify residents, families, authorized representatives, and staff. The Centers for . . . . . Control (CDC) guidance titled "Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities", dated and available online at the time of the survey, directed facilities to "immediately notify the health department" if personnel test positive for COVID-19. It further explained they should "have a plan and mechanism to regularly communicate with personnel, residents, and any family members specified by the resident, including if cases of COVID-19 are identified among residents or personnel." Additional recommendations for source control state "personnel should wear a mask... at all times while they are in the facility." At 10:20 am on . . . . . , the Administrator explained on Staff D served food in the dining room from 6 am to 10 am. She later tested positive and was not working at the time of the interview. When asked if staff and residents were notified , the Administrator said she had provided that information, and a request was made for documentation that would support her statement. She was asked for a list of which resident were notified that a food server had tested positive for COVID-19, but she said it was only a verbal notice and no list was produced at that time.	A 030		

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A 030	Continued From page 8 At 11:49 am on , Resident #7 stated they have had no positive COVID-19 cases in the facility. Staff G, a nurse, indicated on at 12:12 pm that they have had no positive cases in the facility and she believed they would let tell residents and staff if there were any. At 12:46 pm on . . . . . Staff F, a residential assistant, stated she was not aware of any resident or staff member testing positive for COVID-19. On the Administrator was asked at 9:10 am about reporting the positive case to the Department of Health (DOH) that was discovered on . . . . . She said she reported it last Friday, . When asked if staff and residents had been notified of the positive case, she stated the Kitchen Manager was aware and the nurses were notified. When asked about resident notification, she said she talked to the residents about the positive case but there was no documentation to provide to support this. A representative from DOH was interviewed via telephone on . . . . . at 9:24 am. She stated she was not aware of the positive case in this facility until her team called on Friday . . . . . The facility had not called about a positive case since several months prior. She provided the following dates that the facility had positive staff and/or residents: . . . . . , ... , ... , , , , , and . . . . . Additionally, she stated her team has had difficulties getting information from the facility. They sent information to the facility 2 weeks prior on how to report cases in the portal.	A 030		

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A 030	Continued From page 9 Her team is available all the time for reporting information. Staff D was interviewed on /202 at 9:41 am. She stated she believed she left work on , and at home while waiting for symptoms to pass, until returning to work on . When she discovered she tested positive, she reported it to the Kitchen Manager. At 10:30 am on , the Kitchen Manager confirmed Staff D did notify him of her positive test result which he then reported to the Administrator. She continued to say that she knows others tested positive because when someone was not there, everyone starts talking. She also said that while she wears a mask at work, she has seen other staff members without masks on while in the facility. At 11:45 am on , Resident #13 stated as far as he knew, no residents or staff tested positive for COVID-19. Resident #9 stated at 11:55 am on that she thought one staff tested positive a while but this was not confirmed by staff, and went on to explain that communication in the facility is not very good. She said she hears a lot of heresy but she would like to think they would be notified of positive cases. Resident #9 also explained she sees staff not wearing masks and the staff do not encourage residents to wear them. She specifically mentioned the receptionist as a staff member who has been seen without a mask on. On the Agency released a memo explaining the need for facilities to report their daily status related to positive COVID-19 cases in	A 030		

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A 030	Continued From page 10 both residents and staff in the Emergency Status System (ESS) portal. On a review of the ESS portal submission for the facility was reviewed. The information submitted by the facility on revealed no positive COVID-19 results were reported for staff or residents. Further review of the ESS system revealed no positive testing for the period between to . In an interview conducted with Staff E on at 1:10 pm, he explained all information submitted on the ESS portal is provided by the Administrator or other front office staff. Staff E also stated that he was not aware that any staff member had tested positive for COVID-19 in . Staff E stated that if information would have come later in the day after the initial update on the ESS, he could have updated the system. At 1:30 pm on , Resident #14 stated that he had not been made aware of any positive staff or residents of the facility. The Administrator was asked again on at 3:49 pm about notification to residents and staff. She said they knew how to use DOH's website of they wanted to know about any positive cases in the facility. A review of DOH's website that contained a line list of positive cases in long term care settings explained the following: "The information contained in this report reflects the current available information reported by each facility's staff to the Department via the Agency for Health Care Administration's Emergency Status System."	A 030		

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A 030	Continued From page 11 3. On at 10:20 am, the Administrator explained that when a resident leaves, they are required to , for four days upon return. Meals get delivered to their rooms and they can have no contact with anyone but staff. She explained this was required for all medical , , with no exceptions. The facility provided a copy of its "Guidance for Residents and Resident families" dated . It detailed that it was created based on CDC guidance from AHCA and DOH. Section 2 explained that residents who left and did not pass the screening upon return may be denied admission until screening requirements were satisfied. Section 3 mandated that resident who left the premises for a medical , , who passed the screening upon reentry would for four days, followed by a rapid COVID test unless otherwise indicated. Section 4 explained that residents who left for any other reason would be screened and upon allowance into the community would be subject to a 7 day isolation. Examples given were dining out or visits with family. Photographic evidence obtained. In an interview with Resident #8 at 11:35 am on , she stated that if a resident left for a doctor's , , , they had to , for four days. Resident #10's family member was interviewed at 3:16 pm on . Resident #10 was due for another , , , and had been going out to medical , , . Resident #10's family member confirmed there was mention of her going into , after the medical , , but the family refused to allow that to happen because she only went to the doctor and	A 030		

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A 030	Continued From page 12 On ..... the Agency sent a memo to Providers clarifying that Emergency Order 20-009 allowed residents to leave for outside , , . The memo explained,"these residents are not required to be , . upon return to the facility solely based on leaving for an ." After the release of Emergency Order 20-011- the Agency issues a memo to Providers on with information that a Questions and Answers form was available on its COVID-19 website. This from gave guidance about residents leaving the building during the holidays. This form instructed the reader that upon returning the the facility, residents should be screened. If they do not pass the screen they should be or , based on their circumstances. if they passed the screen, then "they do not have to be , or ." Class III	A 030		
A1300	Dem Emerg Order 20-011 Visitation 1. Every facility must continue to prohibit the entry of any individual to the facility, except in the following circumstances: A. Family members, friends, and individuals visiting residents in end- of-life situations including any resident enrolled in hospice; B. Hospice or , care workers caring for residents in end-of-life situations including any resident enrolled in hospice; C. Any individuals or providers giving necessary health care to a resident, provided that	A1300		

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A1300	Continued From page 13	A1300		

such individuals or providers: (1) comply with the most recent Centers for Control and Prevention (CDC) requirements for personal protective equipment (PPE), (2) are screened for signs and symptoms of COVID-19 prior to entry, and (3) comply with the most recent control requirements of the CDC and the facility;

D. Facility staff;

E. Facility residents;

F. Attorneys of Record for residents in Adult Mental Health and Treatment Facilities or forensic facilities for court-related matters if virtual or telephonic means are unavailable;

G. Public Guardians as set forth in chapter 744, Florida Statutes, Professional Guardians as defined by subsection 744.102(17), and their professional staff pursuant to subsection 744.361(14), Florida Statutes;

H. Attorneys and their legal staff who are acting in their capacity as the legal representatives of residents where (a) the residents and lawyers are engaged in an active attorney-client relationships, (b) the visit is related to representation in legal proceedings or in consultation on legal matters, and (c) virtual or telephonic means are unavailable;

I. Representatives of the federal or state government seeking entry as part of their official duties, including but not limited to Long-Term Care Ombudsman program, representatives of the Department of Children and Families, the Department of Health, the Department of Elderly Affairs, the Agency for Health Care Administration, the Agency for Persons with , a protection and advocacy organization under 42 U.S.C. §15041, the Office of the Attorney General, any law enforcement officer, and any emergency medical personnel;

J. Compassionate care visitors who meet the

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ANTHEM LAKES, LLC	905 ASSISI LN JACKSONVILLE, FL 32223

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A1300	Continued From page 14 following definitions and satisfy the following criteria: i. Compassionate care visitors provide support, including emotional support, to help residents deal with difficult transition or loss, upsetting events, end-of-life situations, significant changes (such as recent admission to the facility), the need for assistance, cueing or encouraging with eating or drinking, or emotional distress or decline. ii. Regarding compassionate care visitors, the facility shall: 1. Establish policies and procedures for designation and utilizations of compassionate care visitors; 2. Set a limit on the total number of visitors allowed in the facility based on the ability of staff to safely screen and monitor visitation; 3. Develop an agreeable schedule in concert with the residents and visitors, including evening and weekends, to accommodate work or childcare barriers; 4. Provide instructional signage throughout the facility and prevention and control education, including education on proper use of PPE, hygiene, and social distancing; 5. Designate key staff to support prevention and control training; 6. Screen compassionate care visitors to prevent possible introduction ofCOVID-19; 7. Maintain a visitor log for signing in and out; 8. Monitor visitor adherence to appropriate use of masks, PPE, and social distancing, especially for those who may have difficulty with compliance such as children; and 9. After attempts to mitigate concerns, restrict or revoke visitation if the compassionate	A1300		

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care visitor fails to follow . . . . prevention and control requirements or other COVID-19-related rules of the facility.

iii. Compassionate care visitors shall:

1. Wear a surgical mask and other PPE as appropriate. PPE for compassionate care visitors must be consistent with the most recent CDC guidance for health care workers;

2. Participate in facility-provided training on prevention and control, use of PPE, use of masks, . . . sanitation, and social distancing, and sign acknowledgement of completion of training and adherence to the facility's prevention and control policies;

3. Comply with facility-provided COVID-19 testing, if offered;

4. Visit in the resident's room or in facility-designated visitation areas within the building; and

5. Maintain social distance of at least six . . . with staff and other residents and limit movement in the facility except compassionate care visitors are not required to maintain social distance from the resident being visited.

. The facility may require compassionate care visitors to submit to facility-provided COVID-19 testing so long as use of testing is based on the most recent CDC and U.S. Food and Drug Administration (FDA) guidance.

K. General visitors, i.e. individuals other than compassionate care visitors, under the criteria detailed below:

i. To accept general visitors, the facility must meet the following criteria:

1. Other than in a dedicated wing or unit that accepts COVID-19 cases from the community, the facility must have no new facility-onset of resident COVID-19 cases in the previous fourteen (14) days;

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A1300	Continued From page 16 2. The facility must have fourteen (14) days with no new facility-onset of staff COVID-19 cases where a positive staff person was in the facility in the ten (10) days prior to the positive test; 3. Sufficient staff to support management of visitors; 4. Adequate PPE for staff, at a minimum; 5. Adequate cleaning and supplies; and 6. Adequate capacity at referral hospitals for the facility. ii. General visitors must: 1. Wear a mask and perform proper hygiene; 2. Sign an acknowledgement form noting receipt and understanding of the facility's visitation and prevention and control policies. 3. Comply with facility-provided COVID-19 testing, if offered; 4. Visit in a resident's room or other facility-designated area; and 5. Maintain social distance of at least six with staff and residents, and limit movement in the facility. iii. Before allowing general visitors, the facility shall: 1. Set a policy to prohibit visitation if the resident receiving general visitors is , positive for COVID-19 and not recovered (as defined by most recent CDC guidance), or for COVID-19; 2. Screen general visitors to prevent possible introduction of COVID-19; 3. Establish limits on the total number of visitors allowed in the facility, or with a resident at one time based on the ability of staff to safely	A1300		

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screen and monitor visitation;

4. Establish limits on the length of visits, days, hours, and number of visits allowed per week;

5. Schedule visitors by . , , . only;

6. Maintain a visitor log for signing in and out;

7. Immediately cease general visitation if a resident--other than in a dedicated wing or unit that accepts COVID-19 cases from the community--tests positive for COVID- 19, or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19, or a staff person who was in the facility in the prior ten (10) days tests positive for COVID-19;

8. Monitor visitor adherence to appropriate use of masks, PPE, and social distancing;

9. Notify and inform residents and their representatives of any changes in the facility's visitation policy;

10. Clean and visiting areas between visitors and maintain handwashing or sanitation stations; and

11. Designate staff to support -prevention and control education of visitors on use of PPE, use of masks, . . sanitation, and social distancing.

. Facilities allowing general visitation shall enable general visitation as described in either or both paragraphs 1 and 2 below:

1. Provide outdoor visitation spaces that are protected from weather elements, such as porches, courtyards, patios, or other covered areas that are protected from heat and sun, with cooling devices if needed. The provisions of K.(i) (1) and (2) are not applicable to outdoor visitation.

2. Create indoor visitation spaces for residents in a room that is not accessible by other

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residents, or in the resident's private room if the resident is bedbound and for health reasons cannot leave his or her room.

v. Limit the number of visitors per resident at one time,

vi. Each facility may require general visitors to submit to facility- provided COVID-19 testing so long as use of testing is based on the most recent CDC and FDA guidance.

L. Barbers and beauty salons may resume services to residents with the following precautions:

i. Services are permissible only if:

1. Other than in a dedicated wing or unit that accepts COVID-19 cases, the facility has had no new facility- onset of resident COVID-19 cases in the previous fourteen (14) days; and

2. Fourteen (14) days have passed with no new staff COVID-19 cases where a positive staff person was in the facility in the ten (10) days prior to the positive test.

ii. Barbers and salon staff must wear surgical masks, gloves, practice proper . . hygiene, and follow the same requirements as compassionate caregivers;

iii. Waiting customers must follow social distancing guidelines;

. Residents receiving services must wear . . . . masks;

v. Services are only provided to facility residents, not outside clients or guests;

vi. Services may not be provided to a resident who tests positive for COVID-19 or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19; and

vii. Service and salon areas must be properly cleaned and . . . . . , and equipment must be sanitized between residents.

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A1300	Continued From page 19 2. Individuals seeking entry to the facility, under the above section 1, will not be allowed to enter if they meet any of the screening criteria listed below: A. Any person [illegible] with COVID-19 who does not meet the most recent criteria from the CDC to end isolation. B. Any person showing, presenting signs or symptoms of, or disclosing the presence of a [illegible] including [illegible], chills, [illegible], repeated shaking with chills, new loss of taste or smell, or any other COVID-19 symptoms identified by the CDC. C. Any person who has been in close contact with any person(s) known to be [illegible] with COVID-19, who does not meet the most recent criteria from the CDC to end [illegible]. 3. All facilities must require any individual who is entering the facility and who will have physical contact with any resident to wear PPE pursuant to the most recent CDC guidelines. Persons without physical contact with any resident must wear a [illegible] mask. All facilities are encouraged to provide regular COVID-19 testing for staff and visitors. 4. Any resident leaving the facility temporarily for medical [illegible] or other activities, and any resident receiving visits from health care providers, must wear a [illegible] mask, if tolerated by that resident's condition. All residents must be screened upon return to the facility. [illegible] protection should also be encouraged. [illegible] should be scheduled through the facility or group home to ensure proper screening and adherence to [illegible]-control measures.	A1300		

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A1300	Continued From page 20 5. All visitors must immediately inform the facility if they develop a or symptoms consistent with COVID-19 or test positive for COVID-19 within fourteen (14) days of a visit to the facility. 6. Documentation showing compliance with the following requirements must be kept for all visitation within a facility: A. Individuals entering a facility must be screened. To achieve this purpose, a facility may use a standardized questionnaire or other form of documentation. B. The facility is required to maintain documentation of all non-resident individuals entering the facility. The documentation must contain: i. Name of the individual entering the facility; ii. Date and time of entry; and iii. The screening mechanism used by the facility to conclude that the individual did not meet any of the enumerated COVID-19 screening criteria. This documentation must include the screening employee's printed name and signature. This Statute or Rule is not met as evidenced by: Based on interview, observation, and review of records the facility failed to comply with DEM Emergency Order 20-011 policy to allow compassionate caregivers to provide emotional support to residents within the facility. The lack of compliance with the Emergency Order has the potential to affect all residents of the facility. The Findings Include: On . . . . . , the Agency sent a memo to Providers titled "Long-Term Care Facility Visitation Expectations." In this memo, it clarfied that facilities should "immediately implement	A1300		

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A1300	Continued From page 21 procedures to enable Essential and Compassionate Care visitors to visit your residents." It further explained that Compassionate Care visitors were not required to maintain social distancing, and that it was "critical that you communicate with residents and families your facility status regarding visitation by essential, compassionate, and general visitation." Photographic evidence obtained. Emergency Order 20-011, dated . . . . . ., defined compassionate care visitors as those providing support, including emotional support, to help residents deal with difficult transition or loss, upsetting events, end-of-life situations, significant changes (such as recent admission into the facility), the need for assistance, cueing or encouraging with eating or drinking, or emotional distress or decline. Details of compassionate care visitors in Emergency Order 20-011 showed that these visitors were expected to wear Personal Protective Equipment (PPE) that was consistent with the most recent CDC guidance for health care workers; to participate in control training; to comply with COVID-19 testing if offered; to visit in the resident's room or in facility designated visitation areas within the building; and to maintain social distancing with staff and other residents. Under the heading of Healthcare Workers on CDC's website, the following information was found on the article titled "Interim . . . . . Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus 2019 (COVID-19) Pandemic" dated . . . . "HCP working in facilities located in areas with moderate to substantial community	A1300		

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A1300	Continued From page 22 transmission are more likely to encounter , , or pre- , , patients with SARS-CoV-2 . If SARS-CoV-2 is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis)." CDC's website defined Standard precautions as those used for all patient care. PPE was to be used whenever there "is an expectation of possible exposure to material. Transmission-based precautions are defined by CDC as those used for patients who may be or colonized with certain agents for which additional precautions are needed. Photographic evidence obtained. On , the Agency released a memo directing Providers to read Questions and Answers , Emergency Order 20-11. As part of the Agency for Health Care's "Safe and Limited Re-Opening of Long Term Care Facilities Emergency Order 20-011 Questions and Answers", there was a section titled "Compassionate Care Visitors." Question eleven on this form explained "facilities must allow entry of Compassionate Care visitors who meet the requirements in the order." Question twelve explained "Compassionate Care visitors should discuss their interest with the facility for visitation during a resident's difficult situation or to provide support, including emotional support." Photographic evidence obtained. Review of the facility's website showed the	A1300		

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A1300	Continued From page 23 general visitation policy available for review. The online version was dated explained that general visitation occurred outside on the porch area. They were allowed to continue general visitation even if there were positive cases in the building because porch visits were now "defined as being outdoor visits." Photographic evidence obtained. On at 4:30 pm, an interview was held with the local Ombudsman representative. She indicated they were working with the family of Resident #3 since she was scheduled to move out of the facility soon, and the family wanted to be present as compassionate care visitors to offer emotional support during the process. As of the time of the interview, the facility declined to allow Resident #3's family to come in for compassionate care visitation. On at 10:20 am, the Administrator explained that the facility currently had one compassionate care visitor. When screened, this visitor is allowed to go to the room with PPE on. The expectation is gown, gloves, and masks. They help with tasks like medications. All general visitation occurs on the porch area, with the resident inside, and the visitor on the other side of the window, separated by a screen. At 12:46 pm on , Staff F also stated general visitors stayed on the porch area. Since this area is outside the general visitation could occur even with positive cases. Observation of porch visitation was made on at 2:03 pm. An interview was conducted with Resident #4's family member who	A1300		

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A1300	Continued From page 24 was observed sitting on the patio and visiting through the open window. The family member stated that the facility residents voted not to have inside visitation. He stated he wished that he could have another type of visit instead of visitation from the patio window. On at 9:03am, an interview was conducted with Resident#5. Resident #5 stated that the facility held a meeting in which the residents voted to not have any visitation within the facility. They agreed to continue visitation with visitors wearing masks on the patio and residents inside at the screened windows. He said he wasn't in attendance at the meeting. He really missed not being able to see his family. When asked if aware of compassionate visitation, Resident #5 stated he was not aware there was compassionate visitation. On . . . . . at 11:30 am an interview was conducted with Resident # 6. Resident #6 stated that she was not aware that they could request compassionate care visit. On at 3:01 pm, an interview was conducted with Resident #3. Resident #3 stated that they requested to have compassionate care visitation for emotional support during her move from the facility. She explained she was prone to 's caused by stress. The transition was causing her stress and she wanted her daughter to be present to alleviate her worry. This request was made by her family member at the beginning of . . . . . Resident #3 indicated that several attempts were made to get this approved through the facility administration but Administration failed to respond. At 3:11 pm on , Resident #3's	A1300		

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A1300	Continued From page 25 daughter confirmed in an interview that she wanted to become a compassionate care visitor for her mother. She said that when her mother got overexcited she suffered 's, and she wanted to be present to help avoid that. ('s, short for Transsient , are define by Mayo Clinic as a period of symptoms similar to those of a .) The Administration had not responded to her phone calls. On a review was conducted of an email dated that was sent to Resident #3's family member at 4:13 pm. The email provided the following information to the family member about becoming a compassionate care visitor: she was to complete control training on the free CDC website. There are 23 self-study courses of which 5 were required. She needed to provide proof of a recent test. She needed to provide her own PPE, including gown and gloves. She also had to sign an agreement to comply with the facility's policies. The email also explained Compassionate Care visitors were not permitted access to resident rooms unless the resident was bed-ridden. Resident #3's daughter was denied access to her room. The email stated their policies were "developed with a focus on safety for both residents and staff, and have been reviewed with residents who have expressed strong support for policies that limit the presence of visitors to rooms and apartments" Photographic evidence ontained. On at 4:15 pm the the Administrator stated that the resident voted to not have visitation inside the facility and if you make an exception for one resident you must do it for all of them.	A1300		

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A1300	Continued From page 26 Resident #10 was interviewed on /202 at 3:30 pm. She explained that she was preparing for another , , and did not know how she would handle her illness recurring. She stated her son visits her through the window. On at 3:03 pm an interview was conducted with the family member of Resident #11. She said that she never gets to see her family up close unless she takes her to the doctor's office. When asked if she was aware of compassionate care visitation, she said she wasn't. She stated that the facility never offered her the opportunity. She stated that she got updates from their Facebook page. On at 11:41 am an interview was conducted with the family member of Resident #1. (Resident #1 was seen in her room on . . . . . a 1:26 pm but was not interviewable. She was alert but could not hold a conversation.) The family member stated that they were not allowed to have visits with Resident #1 unless they are through the patio window. Record review showed Resident #1 had a diagnosis of . . . . . and was enrolled with Hospice. On at 3:16 pm an interview was conducted with the family member of Resident # 10. The family member stated that he would love to spend more time with his mother especially since her may have come . He said that she had a hard time with chemo, and she may not want to go through this again. He stated that he was not aware of compassionate visitation with family in the facility.	A1300		

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A1300	Continued From page 27 Class III	A1300		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANTHEM LAKES, LLC	905 ASSISI LN JACKSONVILLE, FL 32223

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

Agency for Health Care Administration

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

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CZ830	Continued From page 2 providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interview and review of records the facility failed to ensure the accuracy of COVID-19 reporting to the Emergency Status System (ESS) for 10 of 20 days sampled. The findings include: On [redacted] at 10:20 am an interview was conducted with the Administrator of the facility. The Administrator indicated that one staff member (Staff D) tested positive for COVID-19 on [redacted]. On [redacted] the Agency released a memo explaining the need for facilities to report their daily status related to positive COVID-19 cases in both residents and staff. The facilities were mandated to report their status daily by 10:00 am until further notice. The Agency's COVID-19 website also provided guidance on how to answer the ESS questions. For the question about how many positive staff members a facility has, the explanation stated facilities were to report the "number of current employees who are currently positive for COVID-19. Exclude any staff who have recovered based on a test based or symptom based strategy." Photographic evidence obtained. Staff D was interviewed on [redacted]/202 at 9:41 am. She stated she believed she left work on [redacted], and [redacted] at home while waiting for symptoms to pass, until returning to work on	CZ830		

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CZ830	Continued From page 3 . . . . . When she discovered she tested positive, she reported it to the Kitchen Manager. At 10:30 am on . . . . . , the Kitchen Manager confirmed Staff D did notify him of her positive test result which he then reported to the Administrator. On a review of the ESS portal submission for the facility was reviewed. The information submitted by the facility on . . . . . revealed no positive COVID-19 results were reported for staff or residents. Further review of the ESS system revealed no positive cases for the period between to . . . . . . In an interview conducted with Staff E on at 1:10 pm, he explained all information submitted on the ESS portal is provided by the Administrator or other front office staff. Staff E also stated that he was not aware that any staff member had tested positive for COVID-19. Staff E stated that if information would have come later in the day after the initial update on the ESS, he could have updated the system. Class III	CZ830		