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
	AL11963788	A. BUILDING: _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANORAMA LIVING	1030 BALMY BEACH DRIVE APOPKA, FL 32703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Complaint investigations (2020016935 and 2020012656) including control and generator monitoring's were conducted at Panorama Living Assisted Living Facility on , and . The facility had a deficiency at the time of the survey.	A 000		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency.	A 152		

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
	AL11963788	A. BUILDING: _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANORAMA LIVING	1030 BALMY BEACH DRIVE APOPKA, FL 32703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 1 (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide a safe living environment for 31 residents of the facility and did not obtain pest control for the indoors when recommended by the county health department. Findings: On ... . at 9:20 AM, staff A stated that she worked in the kitchen and there was a roach problem and the facility is taking care of it. Observations on ... . at 9:30 AM revealed the following in the front area of the facility as follows: When passing through the kitchen, there was a bathroom with a shower that faced the kitchen door, observations revealed there was dark black speckled substance around the doorway of the bathroom and on the door, the shower chair was also covered in the dark black speckled substance. The ceiling in that area had large brown stains. There was peeling wallpaper covered with the black speckled substance that was located between and the exit doorway, there	A 152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11963788	A. BUILDING: _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANORAMA LIVING	1030 BALMY BEACH DRIVE APOPKA, FL 32703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 2 was also a wall next to the outside of bathroom next to covered with the black speckled substance. Further observations revealed the air conditioner vent that led to the entry way of the dining area has a black substance that was around the vents and the area next to the vent was cracked. Review of the county department of health report revealed there was a complaint made as follows: Observations were made of live roaches roaming around the kitchen and main entry way on . . . . . An air conditioning vent (located at entry way) appeared to have a black substance coming from vents. The section that noted violation comments documented the following: Observed: . . . . roaches on sticky trap in dry storage ( ), which is evidence of effective pest control measures, but is a cleanliness issue. Remove traps regularly and maintain cleaning standards. Maintain professional pest control measures to eradicate roach infestation. MUST CORRECT. Observed: vent at entry way, which is in dining area, is rusted and unclean with a black build up and drips from condensation. Ensure no water intrusion issue exists. Clean/Repair. MUST CORRECT Owner response: The owner/administrator, stated on at 11:35 AM that due to the COVID-19 pandemic lock down from to , , professional pest control was suspended at the site because the company on contract, Massey,	A 152		

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
	AL11963788	A. BUILDING: _____ B. WING _____	12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANORAMA LIVING	1030 BALMY BEACH DRIVE APOPKA, FL 32703

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 152	Continued From page 3 refused to have their employees submit to COVID-19 testing and the owner felt that was against AHCA requirements and not in the best interests of her residents. Owner telephoned pest control company while on site. The pest control treated for roaches on the day roaches were observed on and Massey will conduct a follow up on Monday, . The administrator stated her husband (co-owner and maintenance) would be cleaning and painting the vent over the weekend. The owner said on at 11:45 AM, the facility was going to have to make repairs to the roof. The owner said there were roaches found in the kitchen and they did have professional pest control done. He was asked to provide evidence of the professional pest control that was conducted for the interior because it was a recommendation of the county health department. The owner did not have the documentation available at the time of the visit, he was given the opportunity to provide the evidence. On the owner provided the pest control via email that was done for the exterior for and did not include the kitchen as recommended by the department of health. The interior professional pest control was not conducted until . Class III	A 152		