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
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(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 An unannounced Licensure Complaint survey, #2020016326, was conducted from to at Active Senior Living Residence. The facility had a deficiency identified at the time of the survey.	A 000		
A 030 SS=J	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	A 030		

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
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 1 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. [illegible] and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and [illegible]; 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	A 030		

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
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 2 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, 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.	A 030		

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
	AL11965625	A. BUILDING: ______ B. WING ______	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 3	A 030		

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 4 relocation must be set forth in writing and 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	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 5 complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . , . . . or . . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or 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 observations, interviews, record review and policy review, the Assisted Living Facility (ALF) failed to develop and implement control guidelines as directed by the Center for Control and Prevention (CDC) to ensure the health, safety and well-being of residents from the potential to contract or transmit the COVID-19	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 6 . . . The facility failed to ensure administrative oversight to assess, implement, evaluate and monitor their preparedness for response to the COVID-19 pandemic. As evidenced by the facility's failure to implement and establish adequate screening protocols to be followed by the staff. The facility also failed to ensure that CDC recommendations for travel outside of the United States were followed and failed to ensure that COVID-19 positive staff were removed from employment within the facility to prevent continued exposure of the to facility residents and other staff members. This directly affected all residents in the facility, resulting in 24 out of 44 confirmed COVID 19 cases (Residents #1-#24). The findings are: The CDC documents individuals who are 65 years and older, those with . . . . underlying medical conditions, and those living in long-term care facilities are at high risk for developing serious complications from COVID-19 illness. Individuals who are . . . . . could develop serious with difficulty breathing and might require intensive care for the treatment of multi-organ failure, , , failure, and . . , ... COVID-19 . . . . can lead to . . . . COVID-19 is a new . . . , caused by the new Coronavirus that has not previously been seen in humans. Currently, there is no and no approved treatment for COVID-19 . . . . . , which is a highly transmissible . . . See generally, Publications of the Centers for . . . . . Control. On . . . . , The Office of the Governor of Florida issued Executive Order Number 20-51	A 030		

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
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7 directing the Florida Department of Health to issue a Public Health Emergency. The Executive Order documented, "Coronavirus 2019 (COVID-19) is a severe acute illness that can spread among humans through transmission and presents with symptoms similar to those of ." Section 2 directed the State Health Officer to take any action necessary to protect the public health. Section 3 directed the State Health Officer to follow the guidelines established by the CDC (Centers for Control and Prevention) in establishing protocols to control the spread of COVID-19. Section 4 designated the Florida Department of Health as the lead state agency to coordinate emergency response activities among the various state agencies and local governments. On , The Office of the Governor of Florida issued Executive Order Number 20-52 declaring a state of emergency for the entire State of Florida as a result of COVID-19. The President of the United States declared a Nationwide emergency for COVID-19 on and approved a major disaster declaration for Florida on . The CDC publications documents the COVID-19 is thought to spread mainly through close contact from person-to-person, and that the best way to prevent the illness is to avoid being exposed to the . Ways to slow the spread of the include maintaining good social distancing, hygiene, use of cloths, and routine cleaning and of frequently touched surfaces. Review of the facility records and staff interviews	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8 conducted during [redacted] through [redacted], revealed the facility's risk of COVID-19 exposure was greatly increased due to a lack of systematic procedures implemented after potential staff exposure by Staff H (Maintenance Worker) who traveled outside of the United States to Poland from [redacted] through [redacted], returned to work on [redacted]; and developed COVID-19 symptoms on [redacted]. The facility also failed to identify Staff J (Medication Tech), the spouse of Staff H and who lived together as a potential exposure risk of the [redacted] within the facility (after the return of her husband, Staff H) and developed COVID-19 symptoms on [redacted]. As a result of this exposure presented by Staff H and J during their employment in the facility during thru [redacted], 24 residents were exposed to the [redacted] after the return of Staff H to the facility and subsequently tested positive for COVID-19. In addition, 2 direct care staff (Staff A and Staff B) became exposed during this period and tested positive for the COVID -19 around [redacted] and [redacted], respectively. The Administrator allowed Staff A and B to continue to work in the facility after testing positive which contributed to the COVID exposure rate within the facility. The CDC website/publications provides the following guidance to facilities regarding travel and the use of COVID positive staff in the facility. The guidelines as noted by CDC were not implemented within the facility's [redacted] Control Policies ([redacted]) nor followed to prevent the risk of exposure within the facility. The CDC notes the following guidelines and recommendations. A) Review of the CDC's website regarding Travel Health Notices revealed established guidelines for travel outside of the United States as of [redacted]. The following guidance was noted for travel to Poland. CDC	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9 recommendations were noted as the following: 1) The COVID risk is high in Poland. Poland is considered a Level 3 area, to avoid non-essential travel. Some examples of essential travel may include traveling for humanitarian aid work, medical reasons, or family emergencies. Older adults, people of any age with certain underlying medical conditions, and others at increased risk for severe illness should consider postponing all travel, including essential travel, to Poland. 2) If you get sick with COVID-19 (or test positive for COVID-19, even if you have no symptoms) while abroad, you may be or not be permitted to return to the United States until you have recovered fully from your illness. If you get exposed to a person with COVID-19 while abroad, you may be , or not be permitted to return to the United States until 14 days after your last exposure. The CDC recommends the following, after the return of travel from Poland: You may have been exposed to COVID-19 on your travels (domestic and/or international). You may feel well and not have any symptoms, but you can be without symptoms and spread the to others. You and your travel companions (including children) pose a risk to your family, friends, and community for 14 days after you were exposed to the . Regardless of where you traveled or what you did during your trip, take these actions to protect others from getting sick: 1) Stay at least 6 (about 2 arms' length) from anyone who is not from your household. It's important to do this everywhere -- both indoors and outdoors. 2) Wear a mask to keep your and covered when you are outside of your home.	A 030		

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
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10 3) Wash your [illegible] often or use [illegible] sanitizer. 4) Watch your health: Look for symptoms of COVID-19 and take your temperature if you feel sick. 5) Because you have a higher risk for exposure to COVID-19, take additional recommended precautions Because you traveled to a destination where COVID-19 risk is high, also take the following steps after travel: 6) Stay home as much as possible. 7) Avoid being around people at higher risk for severe illness from COVID-19. 8) Consider getting tested for COVID-19. B) The CDC publications/website recommends Strategies to Mitigate Healthcare Personnel Staffing Shortages as the following, last updated on [illegible], as the following: 1) Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including communicating with HCP about actions the facility is taking to address shortages and maintain patient and HCP safety and providing resources to assist HCP with [illegible], and stress. 2) When staffing shortages are [illegible], healthcare facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and prepare for mitigating this problem. At baseline, healthcare facilities must:	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 11 a) Understand their staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care. b) Be in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed. 3) Contingency capacity strategies for healthcare facilities include: a) Adjusting staff schedules, hiring additional HCP, and rotating HCP to positions that support patient care activities. b) Identify additional HCP to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP. c) As appropriate, request that HCP postpone elective time off from work. Review of the facility's . . . . control and prevention ( ) policies and procedures provided by the Administrator for review, (dated as revised on) indicated that it was to enforce immediate actions in case a staff member was suspected or confirmed with COVID-19 to prevent further exposure, transmission or of the COVID-19. The Administrator, at this time, was requested to provide the previous version of the policy, since it was noted as revised on . . . . . However, she indicated this is the only she has available. Review of these policies and procedures established that the facility's Administrator was responsible for the implementation of these procedures and to follow Department of Health (DOH) recommendations relating to the exposure, transmission or	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 12 . . . . . of COVID-19 in long term care facilities. Review of these policies and procedures indicated that staff must be aware of COVID-19 exposure to other staff members and residents and must self-monitor their COVID-19 risk to prevent said exposure. The facility had no written policies and/or process for staff to implement regarding any screening concerns and travel concerns identified based on the completed tool by any individual (including staff) attempting to enter the facility, that would exclude the individual from entering the facility to limit the exposure risk. During an interview with the Administrator on at 11:25 AM, she stated that the facility has policies and procedures. The Administrator provided screenings logs for the staff, review of these logs revealed no procedures or system established to identify potential concerns and COVID risk. The screening forms were being placed in a binder in the Reception Area but never reviewed after completion by the Screener (Staff I) and the Administrator. The facility was also unable to provide evidence that the policy addresses the components of travel and those restrictions. During an interview with the Administrator on at 11:30 AM, the facility's resident COVID-19 status count/history and COVID staff status was discussed. The Administrator provided the following information. She stated that there was a total of 24 residents (Resident #1-#24) who were recently affected by COVID-19 in the facility. She stated all residents were tested on and results received by . . . . . She stated that there were presently 14 residents (Residents #1, 2, 4, 5, 6, 7, 12, 14, 15, 16, 17, 18, 23 and 24) in the facility who were determined to be COVID-19	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 13	A 030		

positive and who presently had no COVID-19 symptoms. She stated that there were another 10 residents (Residents #3, #8, #9, #10, #11, #13, #19, #20, #21 and #22) who were recently hospitalized due to confirmed COVID-19 diagnosis or due to developing COVID-19 symptoms. The Administrator was also, questioned regarding if any staff members had tested positive. The Administrator confirmed that two Direct Care Staff Members had also tested positive (Staff A and B) and were currently working in the facility's COVID unit within the building. She also identified two additional staff with concerns, Staff H, the Maintenance Associate and Staff J, the Medication Tech that worked for the facility during , and that both exhibited signs and symptoms of COVID-19. However, she was unable to provide documentation of COVID testing for these individuals and the results. She further stated, Staff H had requested time off and returned to the facility on . She indicated these individuals were no longer employed by the facility and were terminated for failure to provide their testing results to the Administrator.

Further interview with the Administrator revealed the following regarding Staff H and J. Staff H returned to work after requested personal leave on , and . Staff H developed COVID symptoms on along with his wife (Staff J), both were not feeling well and had a and . Staff H came into work on (passed the screening protocol through screener) for about an hour and was sent home by the Administrator due to his COVID symptoms. The Administrator stated, she never received the test results for Staff H. She stated, Staff H tested for COVID on (per Staff H) and had not received the COVID results;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 14 COVID status unknown. She terminated Staff H from employment on for failing provide the test results to the facility. The Administrator stated, she had no knowledge of Staff H travel to Poland, she had heard rumors from other staff of the travel. However, she never confirmed the actual travel destination for Staff H. Staff J (the spouse of H) worked as the Medication Tech and had direct contact with the residents at the facility on and , after her husband returned from leave. The wife lived and came into direct continual contact with her husband after , she performed medication services to all residents and came in direct contact with residents on and during her shift. She developed symptoms on and never came into work. Staff J last worked at the facility was . Staff J was terminated from employment on due to failing to provide the test results to the facility. In an interview with the Administrator on at 12:45pm, she stated that when she spoke with the Department of Health (DOH) epidemiologist after staff members A and B tested positive for COVID on , she understood that she could schedule these COVID-19 positive staff members to work in the facility with the COVID positive residents without further consideration of additional DOH and CDC guidelines. She stated, that she was told by the Department of Health (DOH) that it was "ok" for these COVID-19 "positive" staff members to continue to work in the facility with COVID-19 "positive" residents, if these staff members were " , ". She stated that when Staff Members A and B tested positive for COVID and in addition to the significant number of residents who tested positive on , the facility had insufficient staffing to manage all the residents' care. She	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 15 stated that she did not initially consider using COVID-19 negative staff members to work in the COVID-19 positive unit due to this. She stated that the facility established the COVID-19 unit in the facility to care for the 14 residents who were positive in # #12 in the west wing of the facility. She stated that she initially staffed this COVID-19 unit with Staff A and B for each 7am-7pm and PM-7am shift starting on . . . . , and she understood that this was likely not enough staffing to provide care to the 14 COVID-19 residents in this unit. The Administrator stated Staff A and B would come in through a separate entrance located on the west side of the building to enter directly into the COVID unit to work their shifts. Further interview with the Administrator on at 12:55 PM revealed an outside agency help/assistance was considered to provide resident care to the COVID-19 unit, but she admitted that she failed to follow-up/provide due diligence with finding this out. She stated and agreed that she took the responsibility to have those two "sick" staff members continue working in the facility and caring for the residents in the COVID-19 unit on and , after they tested positive on . . . . . . Record review of Staff B's employee COVID Unit Log/Schedule indicated that Staff B was working on Monday, ... starting at 7:00 AM in the facility's COVID-19 isolation unit. Record review of Staff B's COVID-19 test by an outside agency dated documented/confirmed that the staff member had tested: "detected/positive" for Severe Acute , , , (SARS)-CoV-2, NAA; as reported to the Department of Health (DOH) on .	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 16 Record review of Staff A's employee COVID Unit Log/Schedule also further indicated that Staff A, was working on Sunday, starting at 7:00 AM in the facility's COVID-19 isolation unit. Record review of Staff A's COVID-19 test by an outside agency dated also documented/confirmed that the staff member had tested: Positive for COVID-19; as reported to the DOH on . An interview was conducted with Staff B, on at 10:00 AM, in which it was revealed that she indicated that she had been tested on Wednesday and the results came on Friday, as: positive. Staff B also stated that she worked only on Monday in the COVID Unit from 7 AM to 7 PM; she added that her doctor told her that she should be An interview was conducted with Staff A, on at 10:29 AM, in which it was also further revealed that she was tested on Thursday, and the results came on Saturday, as: positive. Staff A further stated that she worked only on Sunday, in the COVID Unit from 7 AM to 7 PM; she is currently on . On at 2:42 PM, Staff B reportedly had just called the Administrator to tell her that she is not returning to the facility to work, until she is "cleared", per her own decision. Both Staff B and Staff A reported during their interview on between 10 AM and 10:30 AM, that each was asked/assigned by the Administrator to work in this COVID-19 isolation unit. Staff B indicated that she was only able to monitor the resident's temperatures,	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 17 levels and , rates in the COVID-19 unit once during her shift, in a log, due to having so many COVID positive residents to care for, and working alone in the unit. Staff A indicated that she tried to monitor the resident's temperatures, , levels and , rates in the COVID-19 unit every two hours during her shift, in a log. Staff A also added that she was the only employee working in the COVID positive unit that day and caring for a large group of sick COVID positive residents. They both also expressed that they did have some concerns with working while having a COVID-19 diagnosis of their own, and while working with COVID-19 "positive" residents. However, they both further indicated that they were told by the Administrator that the residents they would be working with, do not have any symptoms. Therefore, both staff members said that they were told that they would not have to worry about getting any sicker because the residents had no symptoms. Review of the facility's control and prevention ( ) policies and procedures dated , it included CDC-Strategies to mitigate healthcare personnel staffing shortages. These guidelines indicated that the facility may implement crisis capacity strategies to provide resident care that included planning to transfer residents to other appropriate designated facilities that had adequate staffing before considering COVID-19 positive staff to care for COVID positive, , residents within the facility. In an interview with Staff H on at 2:50 PM, he stated that he traveled out of the country to Poland from to . He stated that when he first returned to work at the facility on after returning from Poland, he filled	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 18	A 030		

out the facility's COVID-19 screening tool and he did not remember the content of this tool. He stated that no one in the facility asked him about his travel, his completion of the screening tool or the potential risk for COVID-19 transmission due to his recent travel. He stated that he was in contact and lived together with his wife, staff J, whom also worked in the facility. Further interview with Staff H revealed that when he came to work to the facility on , the Administrator told him to leave work since he wasn't feeling well. He stated that he had and symptoms which began on .

In an interview with Staff J on at 2:55 PM, she stated that she lived with her husband, Staff H, and was in direct contact with him since he returned from Poland on . She stated that she worked in the facility on and , and that in her capacity as a medication tech and direct care worker, she came in direct contact with most, if not all the facility residents on and . She stated that she filled out the facility's COVID-19 screening tool before going to work on and and she did not remember the specific contents of this tool. She stated that no one in the facility asked her about her completion of the screening tool or the potential risk for COVID-19 transmission due to her husband's recent travel. She stated that Staff H developed and symptoms on and she developed symptoms on . She stated that her husband and her went to an independent laboratory on to get tested for COVID-19 but they had not received the results yet. She stated that the Administrator terminated her husband and her from employment at the facility on since they didn't have negative COVID-19 test results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 19 Review of Residents' #1, 2, 5, 6, 7, 10, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 24, 25 and 26 Medication Observation Records (MORs) for the month of . . . revealed on . . . and , Staff J provided assistance to each resident's for their self-administration of oral medications. In an interview with Staff I (the Screener) on . . . at 12:55pm, she stated that she was responsible to review all the screening tools/forms before the staff members and other essential individuals come inside the facility. She stated that she usually placed these screening tools inside a binder in the reception area without careful review after each staff member handed the form to the screener in the reception area. She stated that the Administrator was ultimately responsible to review the screening tools after completion by the staff member to ensure that no person with increased COVID-19 risk entered the facility. She stated that if anyone who has traveled outside of the country, as represented in the screen tool question #2, this person was not allowed to come inside the facility due to having increased COVID-19 risk. She stated that she did not have written facility guidelines to follow whenever varying situations may arise in the facility's screening process. In an observation on at 1:00PM, Staff I reviewed Staff H's screening tool form dated on and she stated that she did not request staff H to enter the date of his last COVID-19 test, which was omitted in this tool form. At this time, she also reviewed staff H and J's screening tool form dated on and she stated that these tool forms had missing information under the questions #2: Have you traveled by plane or	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 20 cruise ship within and/or outside the United States in the last 14 days? and question #4: Have you had contact with a person with confirmed or under investigation for COVID-19 within the last 14 days. Further review of the facility screening tool form as completed by Staff H and J dated on indicated that they omitted to complete the information required in questions #2: Have you traveled by plane or cruise ship within and/or outside the United States in the last 14 days? and question #4: Have you had contact with a person with confirmed or under investigation for COVID-19 within the last 14 days. Further review of these screening tools indicated that: "Disclaimer for all individuals completing this screening tool: your signature above indicates you are answering the below questions with honesty and transparency. You also acknowledge not answering truthfully can affect the lives of the residents and staff including . . . . and possible . . . . due to COVID-19. I also acknowledge that I have been provided informational CDC material as requested or needed". In an interview with the Administrator on at 1:45PM, she stated that she was ultimately the person responsible to ensure that every staff screening tool form was completed and if there was any discrepancy in the completion of the tool, that she addressed the matter. She stated that she would deny access to any staff member who presented to have increased COVID-19 risk based on any of the screening tool questions. She stated that the facility did not have written guidelines on the specific actions regarding the completion of the screening tool, the establishment of the facility COVID-unit and the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 21 steps for the staff to take in order to prevent exposure, transmission or of COVID-19 in the facility as it presently cared for residents with and without COVID-19 the diagnosis. In an interview with Staff J on at 10:45 AM, she stated that she received Staff H's screening tool form on (assigned as the Screener on noted date) and that she did not ensure that it was complete and that she did not communicate to Staff I or the Administrator that Staff H had traveled out of the country to Poland from to . She stated that she was not aware of any written facility guidelines for her to follow relating to the COVID-19 screening process. During telephone interviews conducted on the dates of at 12:48 PM and on at 11 AM, respectively with the Department of Health (DOH) Epidemiologist and with the Director of , , both indicated that they did recall having an in-person conversation on Friday and via telephone on Saturday , with the facility's Administrator. In these conversations they both stated that the following was discussed: that in "some" cases for "some" facilities that they might be able to utilize COVID-19 positive/ , staff members to care for COVID-19 "positive" residents in an isolation unit as long as staff have been , for ten (10) days after the first test, or if they were , , it would be ten (10) days after the symptoms have passed. However, both parties stated that they also did stress to the Administrator to follow-up with the Agency for Healthcare for Administration (AHCA) as well regarding staffing. Both DOH staff members went	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965625	A. BUILDING: _____ B. WING _____	10/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTIVE SENIOR LIVING RESIDENCE	9057 NW 57TH STREET TAMARAC, FL 33321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 22 on to say that it would be "unacceptable" utilizing COVID-19 "positive" staff, as a first line option; this would not be the best viable option and should be the last resort. Both DOH staff further added that they would recommend another option be utilized first e.g. the use of staffing agencies to provide temporary staff, or from the facility's other sister facilities, as applicable. An additional interview with the DOH epidemiologist on [redacted] at 2:40 PM, he stated that the facility's COVID-19 outbreak module began with the hospitalization of Resident #22 on [redacted] and facility-wide resident COVID-19 testing began on [redacted]. He stated that all facility residents have been tested by DOH in the facility or in the hospital if hospitalized due to symptoms. He stated that the facility was presently under COVID-19 surveillance by DOH and resident testing was being continually performed. During an exit interview with the Administrator on [redacted] at approximately 2 PM, the findings were discussed. The Administrator provided no additional information. She confirmed that she had not further investigated the travel of Staff H, nor had she implemented symptom-based strategies to prevent the spread of the [redacted] and that the facility had not implemented Strategies to Mitigate Healthcare Personnel Staffing Shortages. Class I	A 030		