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
	AL11942749	A. BUILDING: _____ B. WING _____	01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICKET FENCE MANOR	1662 9TH STREET SOUTH SAINT PETERSBURG, FL 33701

(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 A complaint investigation (complaint number 2021001188), a COVID-19 focused . . . . control visit, and a generator monitoring were conducted at Pickett Fence Manor on . Deficiencies were identified at the time of survey.	A 000		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known . . . . the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical . . . . , the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing	A 054		

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	AL1194274 9	A. BUILDING: _____ B. WING _____	01/21/2021

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A 054	Continued From page 1 physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update Medication Observation Records (MORs) immediately each time medications (meds) were offered and failed to maintain MORs with all required data for twelve (Residents #1, #2, #3, #4, #5, #7, #10, #11, #13, #14, #15 and #16) of fourteen residents sampled residents that required either assistance with self-administration of medications or medication administration. (photographic evidence obtained) Findings Included: A review of the MORs for identified in-house Residents, conducted on [redacted], revealed that Residents #1 and #16 did not have Medication Observation Records. (Photographic evidence obtained) A review of Resident #2's MORs, conducted on [redacted], revealed that the resident's MORs did not contain Resident #2's health care provider's name or telephone number. Resident #2's MORs had prescribed medications that were not documented as given and medications that were documented as given and the dates had not occurred yet. Resident #2's [redacted] 250mcg/50mcg Inhaler was signed as given on [redacted] and [redacted] at 07:00pm and the dates/times had not occurred yet. Resident #2's [redacted] 50mg was not signed as given on [redacted] at 07:00am. Resident #2's [redacted] 175mcg was not signed as given on [redacted] at 07:00am. Resident #2's B-1 100mg was not signed as given from [redacted] through [redacted] at 07:00am.	A 054		

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A 054	Continued From page 2 (Photographic evidence obtained) A review of Resident #3, #5, #7, #10, and #15's MORs, conducted on , revealed that the residents' MORs did not contain Resident #3, #5, #7, #10, and #15s' health care providers names or telephone numbers. (Photographic evidence obtained) A review of Resident #4's MORs, conducted on , revealed that the resident's MORs did not contain Resident #4's health care provider's name or telephone number. Resident #4's MORs had a prescribed medication that was not documented as given. Resident #4's , 5mg was not signed as given on at 08:00am. (Photographic evidence obtained) A review of Resident #11's MORs, conducted on , revealed that the resident's MORs had prescribed medications documented as given and the dates had not occurred yet. Resident #11's 500mcg/50mcg Inhaler was signed as given on at 08:00pm that time had not occurred yet. Resident #11's , 0.5mg was signed as given on at 08:00pm and that time had not occurred yet. (Photographic evidence obtained) A review of Resident #13's MORs, conducted on , revealed that the resident's MORs did not contain Resident #13's health care provider's name or telephone number. Resident #13's MORs had a prescribed medication that was not documented as given. Resident #13's 50mg was not signed as given on at 08:00am. (Photographic evidence obtained)	A 054		

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A 054	Continued From page 3 A review of Resident #14's MORs, conducted on , revealed that the resident's MORs did not contain Resident #14's health care provider's name or telephone number. Resident #14's MORs had a prescribed medication that was not documented as given. Resident #14's D 1000 units was not signed as given on at 08:00am. (Photographic evidence obtained) During an interview with the Administrator, conducted on at 02:50pm, the Administrator agreed that Resident #1, #2, #3, #4, #5, #7, #10, #13, #14, #15 and #16's MORs did not stated the residents' health care providers and telephone number. The Administrator agreed that Resident #2, #4, #11, #13, and #14 had medications not documented as given. The Administrator agreed that Resident #2 and #11 had medications documented as given even though the dates and times had not yet occurred. The Administrator was unable to provide documentation of actual residents residing in the Facility. Class III	A 054		
A 055 SS=D	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept	A 055		

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

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A 055	Continued From page 5 of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, record review, and	A 055		

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A 055	Continued From page 6 interview, the Facility failed to keep centrally stored medication in a locked cabinet or cart secured at all times. Furthermore, the Facility failed to return medications or dispose of discharged residents' medications within thirty days as required. (Photographic evidence obtained) Findings Included: Observations, conducted on . . . . . at 11:43am, revealed that bedroom four had two resident beds and the one bed closest to the door exiting into the living room, had an Diskus 250mcg/50mg and two . . . Hydrofluoroalkane inhalers on a table at the bedside. In the kitchen, there were five paper souffle cups of medication pre-poured stacked on top of the medication cart. There was no identifying information on the souffle cups. Cup one contained one pill. Cup two contained three pills. Cup four contained ten pills. Cup four contained nine pills. Cup five contained three pills. There were two _ monitors and lancing device that were not labeled or separated from oral and medications. The lancing device had smudges of a brownish substance consistent with old . There was a box of lancets belonging to former Resident #17. There were pill packs of medications that were labeled for identified former Resident #18, #19, #20, and #21. (Photographic evidence obtained) A review of the medications, conducted on . . . . . , revealed that the Facility did not have medications for identified current Residents #1, #4, #8, and #16. The Facility had medications for identified former Residents #17, #18, #19, #20, and #21.	A 055		

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A 055	Continued From page 7 During an interview with Staff B, conducted on at 11:43am, Staff B stated that the souffle cups stacked on the medication cart were residents' lunchtime medications and was unable to identify which residents the ˻ . . . . monitors and lancing device belonged to. Staff B stated that Resident #17 did not live at the Facility. During an interview with the Administrator conducted on at 12:25pm, the Administrator stated that Resident #20 was discharged from the Facility last year. At 02:00pm, the Administrator stated that Resident #18 discharged from the Facility a few months ago. The Administrator did not answer the residency status of Resident #19, #20, or #21. At 03:00pm, the Administrator did not respond when questioned as to the reason that identified former Resident #17, #18, #19, #20, and #21's medications continued to be in the Facility. The Administrator did not respond when questioned as to the reason that identified current Residents #1, #4, #8, and #16 did not have medications. The Administrator stated that Resident #20 discharged from the Facility a few months ago. The Administrator was unable to provide documentation of actual residents residing in the Facility. Class III	A 055		
CZ816	408.809(2a-c) 435.05(2) 59A-35.090(2d-3c Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2	CZ816		

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CZ816	Continued From page 8	CZ816		

background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's ... to the Federal Bureau of Investigation for a national criminal history record check unless the person's ... are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the ... of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit ... electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the ... to the Federal Bureau of Investigation for a national criminal history record check. The ... shall be retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person .... The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that:

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CZ816	Continued From page 9 (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer. 59A-35.090 Background Screening. (2) Processing Screening Requests, Required Documents and Fees. (d) An Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , herein incorporated by reference, available at http://www.flrules.org/Gateway/reference.asp?No=Ref-09106, and available from the Agency for Health Care Administration at: http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml. This form must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires	CZ816		

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CZ816	Continued From page 10 Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. (e) An administrator or chief financial officer must be screened and qualified prior to . , , ... to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, a certified letter will be sent to the individual being screened requesting the report and court disposition information. If the letter is returned unclaimed, a copy of the letter will be sent by regular mail. Pursuant to section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with section 435.06(3), F.S. (c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide proof that employees completed an Attestation of Compliance with Background Screening Requirements (Compliance Affidavit) for three (Administrator, Staff A and Staff B) of three sampled employee records.	CZ816		

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CZ816	Continued From page 11 Findings included: A review of the Administrator's employee record conducted on revealed that the there was no documentation that a Compliance Affidavit had been signed and completed by the Administrator. The Administrator was hired on . A review of Staff A's employee record conducted on revealed that the there was no documentation that a Compliance Affidavit had been signed and completed by Staff A. Staff A was hired on . A review of Staff B's employee record conducted on revealed that the there was no documentation that a Compliance Affidavit had been signed and completed by Staff B. Staff B was hired on . An interview was conducted with the Administrator on at 4:50pm and he agreed that the employee records were not up to date. He was unable to provide evidence of signed Compliance Affidavits for any employees. Unclassified	CZ816		
CZ828	408.813(3) FS Administrative Fines; Violations 408.813 Administrative fines; violations.-As a penalty for any violation of this part, authorizing statutes, or applicable rules, the agency may impose an administrative fine. (3) The agency may impose an administrative fine for a violation that is not designated as a	CZ828		

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CZ828	Continued From page 12 class I, class II, class III, or class violation. Unless otherwise specified by law, the amount of the fine may not exceed $500 for each violation. Unclassified violations include: (a) Violating any term or condition of a license. (b) Violating any provision of this part, authorizing statutes, or applicable rules. (c) Exceeding licensed capacity. (d) Providing services beyond the scope of the license. (e) Violating a moratorium imposed pursuant to s. 408.814. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility had eighteen residents residing in the Facility, which had exceeded the Facility's licensed capacity of fourteen residents. Findings Included: Observations and interviews with Residents #1, #2, #3, #7, #8, #9, #10, #11, #12, #14, #15, #16, and the Homeless man, conducted on . . . . . , revealed that Residents #1, #2, #3, #7, #8, #9, #10, #11, #12, #14, #15, #16, and the Homeless man were all in-house residents. A review of the admission and discharge log, conducted on , the admission and discharge log did not have current residents listed and there were residents that were discharged that continued to be listed as current residents. The admission and discharge log identified that the current in-house residents were Residents #2, #3, #4, #5, #6, #7, #10, #11, #12, #13, #14, #15, #20, and #22. Residents #1, #8, #9, and #16 were not listed on the admission and discharge log. This was reviewed with the Administrator and the Administrator provided a list of current	CZ828		

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(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
CZ828	Continued From page 13 residents. The current residents identified by the Administrator were Residents #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15. A review of residents Medication Observation Records (MORs), conducted on , revealed that Residents #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15 had MORs and received their morning medications on . There were no MORs found for Residents #1 and #16. A review of medications in the medication cart, conducted on at 03:00pm, medications were found in the medication cart for Residents #1, #2, #6, #3, #5, #7, #9, #10, #11, #12, #13, #14, #15, #17, #18, #19, #20, and #21. There were no medications found in the medication cart for Residents #4, #8, and #16. Record review for Residents #2, #7, and #13, conducted on , revealed that Residents #2, #7, and #13 were current in-house residents. During an interview with Staff B, conducted on at 01:52pm, Staff B stated that Resident #9 was a current in-house resident and was currently at Program and would return around 02:00pm or 02:30pm. During an interview with the county fire inspector, conducted on , the county fire inspector stated that the Facility's occupant load may be in violation to fire safety. During an interview with the Administrator, conducted on at 11:30am, the Administrator stated that he was hospitalized from through and that he	CZ828		

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	AL11942749	A. BUILDING: _____ B. WING _____	01/21/2021

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CZ828	Continued From page 14 was aware that everything was a mess. At 12:25pm, the Administrator stated that the admission and discharge log was not up to date. The Administrator stated that Resident #20 discharged last year and was unable to provide the date of discharge. The Administrator stated that Resident #22 discharged about six months ago and was unable to provide the date of discharge. At 03:00pm, the Administrator stated that Resident #20 discharged from the Facility a few months ago. The Administrator was unable to explain the reason that medications were kept in the medication cart for discharged residents or the reason that Residents #1 and #16 did not have MORs. During an interview with an investigator for another State agency, conducted on at 09:30am, the investigator stated that on , the investigator observed the medication pass for a total of sixteen residents, which included Residents #9 and #20. It was determined that the current in-house residents of the Facility included Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #20, and the homeless man. Class III	CZ828		
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	CZ830		

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CZ830	Continued From page 15	CZ830		

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 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

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CZ830	Continued From page 16 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 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 record review and interview, the Facility failed to submit a comprehensive emergency	CZ830		

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CZ830	Continued From page 17 management plan (CEMP) for approval and failed to update the Emergency Status System (ESS) daily by 10:00am daily as required. Findings Included: A review of the ESS daily report, conducted on , revealed that the Facility had not updated resident and staff status since . A review of the Emergency Order dated , conducted on , revealed that the Facility was to "maintain up to date and accurate information" daily by 10:00am. During an interview with the local Fire Inspector, conducted on at 01:05pm, the fire inspector stated that the Facility had not had an approved CEMP since . A review of the most recent CEMP approval document, conducted on , revealed that the approved CEMP document provided was dated . During an interview with the Administrator, conducted on at 04:50pm, the Administrator agreed that the Facility was not submitting resident and staff status in the ESS daily by 10:00am and stated that he thought that was eliminated and would start. The Administrator agreed that the Facility had not submitted a CEMP to the local emergency management office for approval. Unclassified	CZ830		

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A 056	Continued From page 18	A 056		
A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must	A 056		

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A 056	Continued From page 19 be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and,	A 056		

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A 056	Continued From page 20 6. Expiration date. (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed to have all medications labeled with all required data. (Photographic evidence obtained) Findings Included: Observations, conducted on at 11:38, Resident #16 was at the dining room table awaiting the lunch meal. At 11:43am, revealed that bedroom four had two resident beds and the one bed closest to the door exiting into the living room, had an Diskus 250mcg/50mg and two Hydrofluoroalkane inhalers without proper labeling on a table at the bedside. At 11:51am, Resident #1 was in a locked bedroom on the second-floor bedroom five. There was only one resident bed in this room. At 02:00pm, the inside of the medication cart was observed to have an 250mcg/50mcg Diskus inhaler and a , inhaler 20mcg/10mcg that were not labeled. (Photographic evidence obtained) During an interview with Resident #16, conducted on at 11:38am, Resident #16 stated that he resided in the Facility and that that the staff provided his medications on time every day. During an interview with Resident #1, conducted on at 11:51am, Resident #1 stated	A 056		

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A 056	Continued From page 21 that he resided alone in bedroom 5 and that the staff provided his medications on time every day. A review of the medications, conducted on [redacted], revealed that the Facility did not have medications for identified current Residents #1, #4, #8, and #16. During an interview with Staff B, conducted on [redacted] at 11:43am, Staff B was unable to identify which resident that the [redacted] 250mcg/50mcg Diskus inhaler and a [redacted] inhaler 20mcg/10mcg belonged to. During an interview with the Administrator conducted on [redacted] at 03:00pm, the Administrator did not respond when questioned as to the reason that identified current Residents #1, #4, #8, and #16 did not have medications. The Administrator agreed to was unable to provide documentation of actual residents residing in the Facility. Class III	A 056		
A 078 SS=D	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable [redacted]. The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management	A 078		

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A 078	Continued From page 22 or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must	A 078		

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A 078	Continued From page 23 specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to obtain annual evidence of a negative examination as required for three (Admin, Staff A and Staff B) of three sampled employees. Findings Included: A record review for Staff A, conducted on , revealed that Staff A did not have evidence from a health care provider that the employee was free from . Staff A was hired on . A record review for Staff B, conducted on , revealed that Staff B did not have evidence from a health care provider that the employee was free from . Staff B was hired on . A record review for the Administrator, conducted on , revealed that the Administrator did not have evidence from a health care provider that he was free from . The Administrator has a hire date of .	A 078		

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A 078	Continued From page 24 In an interview with the Administrator, conducted on at 4:50pm, the Administrator agreed that there was no annual evidence from a health care provider that he and Staff A and Staff B were free from . . . . . He agreed that the employee records were not up to date. Class III	A 078		
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52(1) (1)Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION.	A 081		

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A 081	Continued From page 25 (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in [illegible] control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its [illegible] control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to [illegible] borne [illegible], may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers	A 081		

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A 081	Continued From page 26 the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident , neglect, and , ... The facility must use its prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response	A 081		

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	AL11942749	A. BUILDING: _____ B. WING _____	01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICKET FENCE MANOR	1662 9TH STREET SOUTH SAINT PETERSBURG, FL 33701

(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 081	Continued From page 27 policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provideNutritional and Safe Food Handling Training for two (Staff A and Staff B) of three sampled employees. Findings Included: An employee record review for Staff A (Resident Aide), conducted on . . . . . , revealed that Staff A's employee record did not contain evidence of training for Nutritional and Safe Food Handling. Staff A has a hire date of . An employee record review for Staff B (Resident Aide), conducted on . . . . . , revealed that Staff B's employee record did not contain evidence of training in Nutritional and Safe Food Handling. Staff B has a hire date of . During an interview with the Administrator, conducted on at 4:50 pm, the Administrator agreed the employee training and records were not up to date. He was unable to provide evidence of Incident Reporting Training for Staff A or Nutritional and Safe Food Handling Training for Staff A and Staff B. Class III	A 081		
A 082 SS=D	59A-36.011(4) FAC Training - / . . (4)	A 082		

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A 082	Continued From page 28 (/), Pursuant to section 381.0035, F.S., all facility employees, with the exception of employees subject to the requirements of section 456.033, F.S., must complete a one-time education course on and , including the topics prescribed in the section 381.0035, F.S. New facility staff must obtain the training within 30 days of employment. Documentation of compliance must be maintained in accordance with subsection (12), of this rule. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to ensure that newly hired employees had the required one-time education course on / , (/) Training for two employees (Staff A and B) of three sampled employees within thirty-days of employment. Findings Included: An employee record review conducted for Staff A on , revealed that there was no evidence in the employee record that the staff had completed the required one-time training on / within thirty days of employment. Staff A was hired on . An employee record review for Staff B, conducted on , revealed that there was no evidence in the employee record that the staff had completed the required one-time training on / within thirty days of employment. Staff B was hired on . During an interview with the Administrator,	A 082		

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A 082	Continued From page 29 conducted on at 4:50pm, the Administrator agreed that the employee records were not up to date. He was unable to provide evidence of training in / for Staff A and Staff B. Class III	A 082		
A 083 SS=D	59A-36.011(5) FAC Training - First Aid and (5) FIRST AID AND ( ). A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation that the staff member possess current certification that requires the student to demonstrate, in person, that he or she is able to perform and which is issued by an instructor or training provider that is approved to provide training by the American Red Cross, the American Association, the National Safety Council, or an organization whose training is accredited by the Commission on Accreditation for Pre-Hospital Continuing Education satisfies this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, Part III, F.S., shall be considered as having met the training requirements for both First Aid and C.P.R. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to provide direct care staff on each shift with updated training in ( ) and First Aid as required, for	A 083		

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A 083	Continued From page 30 three (Admin, Staff A and Staff B) of three sampled employees. Findings Included: A record review for the Administrator, conducted on . . . . . , revealed that Administrator's . and First Aid Trainings had expired on . . . . The Administrator's date of hire was . . A record review for Staff A, conducted on . . . . . , revealed that Staff A's . and First Aid Trainings had expired on 11/28/2020. Staff A's date of hire was . . . . . . A record review for Staff B, conducted on . , revealed that Staff B's and First Aid Trainings had expired on 11/28/2020. Staff B's date of hire was . During an interview with the Administrator, conducted on . . . . . at 4:50pm, the Administrator agreed that Staff A and Staff B's employee records did not contain evidence of current and valid and First Aid Training. The Administrator agreed that the employee records were not up to date. Class III	A 083		
A 084 SS=D	59A-36.011(6) FAC 429.52(6), FS Training - Assis Self-Admin Meds & Med Mgmt 59A-36.011 (6) ASSISTANCE WITH THE SELF-ADMINISTRATION OF MEDICATION AND MEDICATION MANAGEMENT. Unlicensed persons who will be providing assistance with the	A 084		

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A 084	Continued From page 31 self-administration of medications as described in rule 59A-36.008, F.A.C., must meet the training requirements pursuant to section 429.52(6), F.S., prior to assuming this responsibility. Courses provided in fulfilment of this requirement must meet the following criteria: (a) Training must cover state law and rule requirements with respect to the supervision, assistance, administration, and management of medications in assisted living facilities; procedures and techniques for assisting the resident with self-administration of medication including how to read a prescription label; providing the right medications to the right resident; common medications; the importance of taking medications as prescribed; recognition of side effects and adverse reactions and procedures to follow when residents appear to be experiencing side effects and adverse reactions; documentation and record keeping; and medication storage and disposal. Training shall include demonstrations of proper techniques, including techniques for control, and ensure unlicensed staff have adequately demonstrated that they have acquired the skills necessary to provide such assistance. (b) The training must be provided by a registered nurse or licensed pharmacist who shall issue a training certificate to a trainee who demonstrates, in person and both physically and verbally, the ability to: 1. Read and understand a prescription label; 2. Provide assistance with self-administration in accordance with section 429.256, F.S., and rule 59A-36.008, F.A.C., including: a. Assist with oral dosage forms, , dosage forms, and , , , and dosage forms; b. Measure liquid medications, break scored	A 084		

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A 084	Continued From page 32 tablets, and crush tablets in accordance with prescription directions; c. Recognize the need to obtain clarification of an "as needed" prescription order; d. Recognize a medication order which requires judgment or discretion, and to advise the resident, resident's health care provider or facility employer of inability to assist in the administration of such orders; e. Complete a medication observation record; f. Retrieve and store medication; g. Recognize the general signs of adverse reactions to medications and report such reactions; h. Assist residents with syringes that are prefilled with the proper dosage by a pharmacist and that are prefilled by the manufacturer by taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident for self-injection; i. Assist with ; j. Use a to perform testing; k. Assist residents with and continuous positive airway pressure (CPAP) devices, excluding the titration of the levels; l. Apply and remove stockings and hosiery; m. Placement and removal of bags, excluding the removal of the or manipulation of the site; and, n. Measurement of , rate, temperature, and rate. (c) Unlicensed persons, as defined in section 429.256(1)(b), F.S., who provide assistance with self-administered medications and have successfully completed the initial 6 hour training,	A 084		

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A 084	Continued From page 33 must obtain, annually, a minimum of 2 hours of continuing education training on providing assistance with self-administered medications and safe medication practices in an assisted living facility. The 2 hours of continuing education training may be provided online. (d) Trained unlicensed staff who, prior to the effective date of this rule, assist with the self-administration of medication and have successfully completed 4 hours of assistance with self-administration of medication training must complete an additional 2 hours of training that focuses on the topics listed in sub-subparagraphs (6)(b)2.h.-n. of this section, before assisting with the self-administration of medication procedures listed in sub-subparagraphs (6)(b)2.h.-n. 429.52 (6) Staff assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or a licensed pharmacist before providing assistance. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this training This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees had the required training in Assistance with Self-Administration of Medications, prior to assisting residents with medications, for two of (Staff A and Staff B) of three sampled employees. Findings Included: A record review for Staff A, conducted on [redacted], revealed that Staff A's record did not	A 084		

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A 084	Continued From page 34 contain evidence that Staff A had attended a six-hour training on Assistance with Self-Administration of Medications prior to assisting residents with medications. There was no evidence of the two-hour annual update training in Assistance with Self-Administration of Medications since . Staff A was hired on . A record review for Staff B, conducted on , revealed that Staff B's record did not contain evidence that Staff B had received the two-hour annual update training in Assistance with Self-Administration of Medications since . Staff B was hired on . During an interview with the Administrator, conducted on at 4:50pm, the Administrator confirmed that the employee files were not up to date. He was unable to provide evidence of completion of the required medication training for Staff A or Staff B. Class III	A 084		
A 092 SS=D	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module	A 092		

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A 092	Continued From page 35	A 092		

of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices.
(b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule.
(c) An administrator or designee must perform his or her duties in a safe and sanitary manner.
(d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets.
(e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, the Facility failed to comply with the food service continuing education requirements specified in rule 59A-36.011, Florida Administrative Code.

Findings Included:

A review of the Administrator's employee record, conducted on , revealed that the Administrator did not have safe food handling or other food service training in his employee record.

A review of the county health departments inspection report dated , conducted on

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A 092	Continued From page 36 . . . . . , revealed that the county health department inspectors cited the Facility for Violation #2, which stated that "at time of inspection, person in charge does not have current certification" and that the "person in charge is present but has expired certification". This was a repeat violation. During an interview with the Administrator, conducted on at 04:50pm, the Administrator agreed that his employee record was not up to date and that he did not have current training as the food service designee. Class III	A 092		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food	A 093		

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A 093	Continued From page 37 habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider.	A 093		

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A 093	Continued From page 38 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of . . . . . the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . . . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on . . . at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must	A 093		

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A 093	Continued From page 39 also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the Facility failed to have regular menus approved by a registered dietitian annually. Additionally, the Facility failed to log menu substitutions and keep dated menus and substitution records on file for six months. Also, the Facility failed to provide substitutions of equal nutritive value. Furthermore, the Facility failed to serve meals in a safe manner. (Photographic evidence obtained) Findings Included: During observations of the lunch meal preparations, conducted on [redacted] at 11:35am, there were eighteen plates lined up on the counter in the kitchen. There were no covers for the food and house flies were flying in and around the food on the plates. Residents were coming and going through the meal preparation area and used the kitchen as the main thoroughfare in and out of the Facility. Staff B and E were not wearing hairnets or gloves during the meal preparation. At no time was Staff B or E observed performing handwashing during the lunch meal preparation. At 12:00pm, Resident #2 was observed delivering plates of food to resident that were sitting in the dining room. The meal on the plates was Corn Dogs, French Fries, Potato Salad, Prunes, and two Cookies. (photographic evidence obtained) A review of the posted menu, conducted on [redacted], revealed that the Facility's posted	A 093		

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(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 093	Continued From page 40 menu was approved by the registered dietician on . The menu cycle was week three and stated that the lunch meal for Thursday was Salisbury Steak, Tator Tots, Veggie Soup with Crackers, Bread, Fruit Cup, and Low-fat Milk. (photographic evidence obtained) A review of menus, conducted on , revealed that the Facility had two sets of menus in four cycles, approved by a registered dietician on file. One cycle of menus was dated and the other cycle of menus was dated . . . . . There were no menu cycles approved by a registered dietician for the years 2020 or 2021. (Photographic evidence obtained) A review of the substitution log, conducted on , revealed that there were no entries on the substitution log. (photographic evidence obtained) A record review for Resident #2, conducted on . . . . . , revealed that Resident #2 was a resident and not employed at the Facility. Resident #2 had no evidence of training for safe food handling or compensation for work provided to the Facility. Resident #2 was admitted to the Facility on . A review of the Facility dining policy and procedures, conducted on . . . . . , revealed that the Facility was not following their own dining policy and procedures. The dining policy and procedures stated that meals were chosen from a printed menu that had been reviewed and approved by a registered dietician. (photographic evidence obtained) During an interview with Staff E, conducted on at 12:00pm, Staff E did not respond	A 093		

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A 093	Continued From page 41 when questioned if the lunch meal served was a substitution. During an interview with the Administrator, conducted on [redacted], the Administrator agreed that the Facility did not have menu cycles approved by the registered dietician for the years 2020 or 2021. The Administrator agreed that the posted menu was not current. The Administrator agreed that there had been no entries on the substitution log and that the lunch meal served was not the lunch meal posted. Class III	A 093		
A 094 SS=D	59A-36.012(3) FAC Food Service - Food Hygiene (3) FOOD HYGIENE. Copies of inspection reports issued by the county health department for the last 2 years pursuant to rule 64E-12.004, or chapter 64E-11, F.A.C., as applicable, depending on the licensed capacity of the assisted living facility, must be on file in the facility. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to maintain copies of inspection reports issued by the county health department for two year pursuant to rule 64E-12.004, or chapter 64E-11, Florida Administrative Code. Findings Included: An attempt to review the county health inspection reports, conducted on [redacted], revealed that the Facility did not have any to review and did not maintain the county health inspection reports at the Facility.	A 094		

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A 094	Continued From page 42 During an interview with the Administrator, conducted on [redacted] at 04:50pm, the Administrator was unable to provide the documents. Class III	A 094		
A 152 SS=J	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 [redacted] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [redacted] 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	A 152		

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A 152	Continued From page 43 event of an emergency. (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 observation, record review and interview, the facility failed to provide a clean, safe, and decent living environment free from bedbugs, fruit flies, and house flies and failed to provide building repairs and maintenance as needed for widespread structural damage. Additionally, the facility failed to have sufficient bathing and toileting facilities for residents' use and failed to ensure adequate functioning fire safety equipment, lighting, and evacuation routes. Furthermore, the deplorable conditions in the facility placed all residents at risk of injury and/or illness to their health and safety. Findings Included: Observations of the first floor of the facility conducted on . . . . . beginning at 11:33am revealed the following: (Photographic evidence obtained) - Bedroom #1: the bedroom contained two resident beds and there was a complete bed with a bedframe blocking a doorway. The floor was dirty and contained cigarette ashes, dried drips of unknown black substance, trash, and dirt/dust buildup. The baseboards had extreme dust accumulation and the metal floor air vent was rusted and was caked with dust, grime, and hair.	A 152		

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A 152	Continued From page 44 At 11:38am, the comforters were observed as soiled, there were loose electrical running across the floor from under one of the beds, and the electric outlet was not secured to the wall and had about a one-inch gap behind it. - Bedroom #2: the bedroom contained two resident beds. The floor was dirty and covered in dirty clothing and dirt buildup. There were dirty socks lying on top of the air vents and the baseboards had extreme dust accumulation. The two metal floor air vents were rusted and caked with dust, grime, and hair. There was debris and dirt on top of the nightstand and floor. There were cigarette ashes and butts covering the window ledge touching the bedding. There were five bins of clothing stacked on top of each other and there was a foul odor coming from the bins. - Bathroom #1: there was a white shower chair inside the shower, that was covered in black discoloration consistent with mold and/or dirt (bio-growth). The metal chair appeared corroded. The shower walls and floor had bio-growth. The shower curtain was covered in soap scum and/or mildew. There was trash on the floor of the shower and the drain was corroded and covered in soap scum. The metal floor air vent was rusted with broken jagged edges. The sink had an accumulation of dirt, dust, and bio-growth. The empty soap dispenser and mirror had dried splatters of unknown substances. The electrical outlet was covered in dirt and scum buildup. The toilet contained standing and had cigarette butts and trash in it. The toilet was covered in dust accumulation and the air smelled of foul . The residents residing in Bedroom #1 and #2 were using this bathroom.	A 152		

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A 152	Continued From page 45 - Living Room: there were two white sofas that were cracked and covered in black dirt and stains. There were three residents sitting on the sofas. The end table were smeared with an unknown substance. The windows between the living room and dining room were smudged with unknown substances. The door leading into bedroom four had black dirt or stains and there was food consisting of eggs and grits splattered all over the door and the door frame. - Dining Room: there were two rusted metal floor air vents that were caked in dust, grime, and hair. There was broken floor tiles in front of the entry door and around one of the air vents near bedroom three. The electrical outlet was missing the plate. There was an unknown substance coming through a hole in the wall from the exterior of the home. The floor was not clean and was covered in blackness from dirt, food drippings, or bio-growth. The wall behind the trash can had dried drips and splatters from unknown multi-colored (orange, black, brown, red) substances. - Bedroom #3: the bedroom contained three resident beds. There were two broken, rusty, and dusty metal floor air vents in which trash was lying on one of the air vents. There were cigarette butts and trash lying on the floor. The white wardrobe cabinet was smeared with a black substance that was not able to be identified. There were multiple moldy/mildew spots on the ceiling near the light fixture. The ceiling had pieces of broken wood and the wall behind an unidentified resident's bed had water dripping from the second floor/ceiling. - Kitchen: Staff B and Staff C were preparing the lunch meal with eighteen plates of food lined	A 152		

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A 152	Continued From page 46 up on the counter and residents were walking through the kitchen and using the narrow passage through the kitchen as the main thoroughfare in and out of the facility. The medication cart parked in the kitchen was used as an additional food preparation area. There were flattened cardboard boxes stacked next the stove that was in use cooking the lunch meal. At 12:10pm, Resident #3 was sweating and walked through the kitchen where the food preparation was taking place by Staff B with a canvas bag overflowing of clothing and sneakers that smelled foul. Staff B did nothing to stop the resident from entering and walking through the food preparation area with uncovered food. - Bedroom #4: the bedroom contained two resident beds. There were broken floor tiles at the entry door from the bathroom hallway. There were cigarette butts, dust, and dirt accumulation on the floor. The bedside table was covered with a towel that had bug carcasses on it and trash. The laundry basket and trash can were on top of a metal floor air vent. The window ledge had dirt and dust accumulation and grime buildup. - Laundry Room/Employee Bathroom: there was one toilet that had bio-growth inside the bowl. There was a large tub style sink that employees were to use for handwashing after using the toilet that was covered in bio-growth, dirt accumulation, and bug carcasses. The dirty broom was leaning against the sink and the mop bucket had a buildup of dirt and scum covering it. - Bathroom #2: there was small, narrow hall between bedroom three and bedroom four and this bathroom door was in the hallway. The light switch in the hall would not turn the light on. The	A 152		

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A 152	Continued From page 47 switch was corroded and covered in grime and black stains. A swarm of flies and fruit flies flew up when the bathroom door was opened. There was water on the floor mixed with , dirt, debris, and feces. There was a strong odor of , which made it difficult to enter even with a mask on. There was standing in the toilet. The bathtub did not have grout/caulking between the tub and the walls surrounding the bathtub and was covered in bio-growth, dirt, and soap scum. There were two bar soaps out for multiple resident use. There were wall boards and a walker stored behind the door. The wall and flooring behind the door had broken tiles. Residents residing in Bedroom #3 and #4 were using this bathroom. Observations of the second floor of the facility conducted on beginning at 11:51am revealed the following: (Photographic evidence obtained) - Bedroom #5: the bedroom contained one resident bed. There was a foul odor of cigarette smoke in the room and a broken electrical outlet. There was a table with a makeshift cigarette ashtray from an food container and cigarette ashes covering the table. There was a broken corroded electrical outlet covered in dirt/dust/grime/cigarette ashes. The floor was covered in dirt/dust/cigarette ash accumulation. On top of the dresser there was a coffee pot that appeared to be in use sitting inside a large tray, which was also used as a cigarette ashtray. - Bedroom #6: the bedroom contained two resident beds. The floor had dust/dirt/grime accumulation, cigarette butts lying on the floor, and the base boards were covered in dirt/grime	A 152		

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A 152	Continued From page 48 accumulation. The box spring mattress was torn, and the bed was in front of one egress door. The walls were covered in dirty black discoloration and stains. The closet flooring was coming up and the door had grime buildup of unknown substance and [illegible] stains. There were two [illegible] beds pushed flush with the closet and one egress exit door. One closet had a bolt lock attached that was unlocked and the other had a sliding bolt and was unable to be opened. The floors were covered cigarette ashes and cigarette butts. The floor linoleum was lifting away from the floorboards between the bed and the wall and behind the door. The dresser had six drawers, and all were broken. The ceiling fan was not attached to the ceiling securely and had a two-inch gap. There was only one light bulb that worked. The ceiling fan blades were covered in half an inch of dust. One resident used a white garbage can to store his clothing. The ceiling air vent was dusty and blowing out black dust that covered the ceiling in two dirt stripes. - Stairwell: the stairwell had dust/dirt/grime build up to stairs and trash and cigarette butts. The window blinds were broken. The stair railing was covered with an extreme accumulation of dust/grime/dirt. The window ledge with dust, food, a dried gelatinous blob of unknown origin, and a one inch long thick pile of cigar or cigarette ashes, with dirt and dust accumulation and [illegible] pest/bug carcasses. The second-floor egress was boarded up due to rusted, rotting, and missing stairs. The fire extinguisher that was in the hall was last inspected in [illegible]. Bio-growth was observed in the ceiling on the attic access wood next to an uncovered lightbulb that provided the only hallway light. - Bedroom #7: contained two bed sets	A 152		

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A 152	Continued From page 49 including mattress and box springs. Both sets were leaning up against the wall with one box spring covering a window. There were two metal rusty bed frames leaning against the wall. There was a large area of linoleum flooring lifted from the cement floor in the corner of the room and laying rolled up under the bed frame. There was a lighter, cigarette butts, an empty cigarette package, trash and cigarette ashes laying on the floor. The wall was all windows and the windowsills were covered in dirt and dust. - Bedroom #8: the bedroom contained two resident beds. There were huge piles of foul-smelling clothing on the floor. The window ledge contained a drinking glass, a vape container, cigarette ashes, dirt, grime, and bugs. The table was smeared with unknown substances. The white bedside cabinet was covered on black dirt/grim. There was trash on the floor. One box spring mattress was torn. The floor was covered in dirt/grime dirt/grime buildup. The ceiling air vent contained severe dust accumulation. - Bathroom #3: was the only bathroom on the second floor and had one sink, toilet, and shower stall and did not appear to be in use as there was a cardboard box of miscellaneous items in the shower stall and did not have a shower curtain. The baseboards were dirty to the side of the sink and the baseboards behind the sink were missing. The bathroom sink basin was covered in soap scum and dirt. Observations of the exterior of the facility conducted on beginning at 11:55am revealed the following: (Photographic evidence obtained)	A 152		

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A 152	Continued From page 50 - Front Yard and Exterior: the dining room's red entry door with black and white discoloration of unknown substance possible bio-growth or dirt/grime accumulation. There was trash throughout the front and sides of the yard, which included trash, a pile of empty beverage cans, broken furniture, and eleven rotting boards with nails lying next to the entry steps. - Yard: at 01:18pm through 01:32pm, near the second-floor egress stairwell was cluttered with debris which included trash, rotting wood, stacks of blocks, paint cans, skateboard, trim, bed rails, and other items. During an interview with Staff B, conducted on at 12:10pm, Staff B stated that Resident #3 frequently went dumpster diving and brought dirty items into the facility. A review of the resident's policy and procedures (P&P) documented in resident contract, conducted on , revealed that the facility was not following their policy and procedures. The P&Ps stated as followed: " The housekeeping P&P stated that laundry of personal items and linens were included with residents' monthly fees and clean towels were provided bi-weekly and bed linens will be changed weekly or when necessary. " The toiletries P&P stated that the staff would ensure that each bathroom was supplied with soap. " The maintenance P&P stated that all repairs will be made as soon as possible, and all building repairs and light bulb replacement will and must be handled by the Facility's staff.	A 152		

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A 152	Continued From page 51 " The pest control P&P stated that the Facility was treated monthly in order to maintain high standards. " The smoking P&P stated that there was to be "NO Smoking in the building" and "a smoking area is provided on the outside of the building and the activity room" and there were "NO EXCEPTIONS TO THIS POLICY!" (Photographic evidence obtained) During an attempt to review the housekeeping cleaning schedule, conducted on , there was no housekeeping cleaning schedule provided. A review of the local health inspection reports, conducted on . . . . . , revealed that the local health inspection team issued unsatisfactory inspection reports. The group care inspection report dated listed twenty-four violations and the group care inspection report dated listed the same violations. The food inspection report dated . . . . . listed ten violations and the food inspection report dated listed the same violations. The local health inspectors were onsite during survey and the facility continued with an unsatisfactory inspection and the violations were yet to be determined. (Photographic evidence obtained) An interview with the County Fire Inspector, conducted on at 01:17pm, the Fire Inspectors stated that the facility had not completed a fire drill since and all of the fire extinguishers were out of date. The Fire Inspcetors stated that the last satisfactory fire inspection was on . . . . . . The Fire Inspector stated that it had been a couple of years since the	A 152		

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A 152	Continued From page 52 facility had the fire sprinkler tested. At 02:10pm, the Fire Inspector stated that there were no hard wired smoke detectors in the Facility. The Fire Inspector stated that the egress stairwell was boarded up by the Fire Inspectors on . The Fire Inspector stated that the Facility had three powere strips piggybacked off of each other to one electrical outlet. A review of the pest control contract and/or visits, conducted on , revealed that there had been no pest control visits from any exterminator since . (Photographic evidence obtained) During an interview with Resident #8, conducted on at 04:40pm, Resident #8 stated that the upstairs bathroom had not been in use by residents and had been locked until this week. Resident #8 expressed dissatisfaction with the lack of cleanliness and toileting access. A review of 'A Brief Guide to Mold and Your Home' found at (https://www.epa.gov/mold/brief-guide-mold-moisture-and-your-home) dated , conducted on , stated that "Molds have the potential to cause health problems. Molds produce (substances that can cause reactions), irritants, and in some cases, potentially toxic substances (mycotoxins). Inhaling or touching mold or mold spores may cause reactions in sensitive individuals." The article stated that the key to mold control is moisture control. A review of 'Fire Prevention and Safety in Healthcare Settings' copyrighted 2021 found at (https://study.com/academy/lesson/fire-prevention-safety-in-healthcare-settings.html), conducted on	A 152		

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, the article stated that "the best way to prepare for a fire is to learn how to prevent one". The article included steps within the environment that was needed, which included but not limited to functional alarms, extinguishers, functional, fire suppression systems, and functional evacuation routes. The article stated that fire safety was everyone's responsibility in a facility.

A review of ' Making a Home Sanitary' found at (https://www.clutterhoardingcleanup.com/resources/organization-and-sorting/unsanitary-home-cleaning#:~:text=Unsanitary%20conditions%20can%20affect%20your%20health%20in%20a,a%20person%20to%20become%20sick%20when%20breathed%20in.) dated , conducted on , the article stated that there is cause for concern in living in a home with unsanitary conditions. The article stated that issues such as mold can affect your health in a number of different ways. The article stated that mold can cause " and to be released into the air which can cause a person to become sick when breathed in".

During an interview with the Administrator, conducted on at 11:30am, the Administrator stated that he was in the hospital from through and that everything would be corrected now that he returned to work. The Administrator stated that the facility did not have a plan for ridding the facility of bedbugs. In a follow up interview conducted at 04:50pm, the Administrator agreed that the conditions at the facility had become deplorable and that the facility needed immediate building repairs, cleaning, and pest control to all resident rooms, bathrooms, and common areas.

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	AL11942749	A. BUILDING: _____ B. WING _____	01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PICKET FENCE MANOR	1662 9TH STREET SOUTH SAINT PETERSBURG, FL 33701

(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 54 Class I	A 152		
A 160 SS=D	59A-36.015(1) FAC Records - Facility The facility must maintain required records in a manner that makes such records readily available at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a [redacted]; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of [redacted]. (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph	A 160		

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A 160	Continued From page 55 (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in rule 59A-36.019, F.A.C., that must be readily available by facility staff. (e) The facility's liability insurance policy required in rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in rule 59A-36.007, F.A.C. (j) All food service records required in rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to section 429.41, F.S., and rule chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to section 381.031, F.S., and chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to section 429.35, F.S., all	A 160		

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A 160	Continued From page 56 completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures. (o) The facility's documented resident elopement response drills. (p) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the Facility's license and the Hotline telephone number in a conspicuous and public place within the Facility. Furthermore, the Facility failed to maintain an up to date admission and discharge log. Findings Included: A review of the admission and discharge log, conducted on , revealed that the admission and discharge log was not up to date. Resident #20 was admitted on and there was no discharge data for the resident. Resident #22 was admitted on and there was no discharge data for the resident. Residents #1, #8, #9, #10, and #16 were identified as current resident during survey and there was no admission data for these residents on the admission and discharge log. During an interview with the Administrator, conducted on at 12:25pm, the	A 160		

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A 160	Continued From page 57 Administrator agreed that the admission and discharge log was not up to date. The Administrator stated that Resident #20 was discharged from the Facility last year and Resident #22 was discharged about six months ago. At 03:00pm, the Administrator stated that Resident #20 discharged a few months ago. The Administrator was unable to provide discharge data for Residents #20 or #22. The Administrator was unable to provide admission data for Residents #1, #8, #9, #10, or #16. Class III	A 160		
A 161 SS=D	429.275(2) FS; 59A-36.015(2) FAC Records - Staff 429.275 (2) The administrator or owner of a facility shall maintain personnel records for each staff member which contain, at a minimum, documentation of background screening, if applicable, documentation of compliance with all training requirements of this part or applicable rule, and a copy of all licenses or certification held by each staff who performs services for which licensure or certification is required under this part or rule. 59A-36.015 (2) STAFF RECORDS. (a) Personnel records for each staff member must contain, at a minimum, a copy of the employment application, with references furnished, and documentation verifying freedom from signs or symptoms of communicable . . . . . In addition, records must contain the following, as applicable: 1. Documentation of compliance with all staff	A 161		

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A 161	Continued From page 58 training and continuing education required by rule 59A-36.011, F.A.C., 2. Copies of all licenses or certifications for all staff providing services that require licensing or certification, 3. Documentation of compliance with level 2 background screening for all staff subject to screening requirements as specified in section 429.174, F.S., and rule 59A-36.010, F.A.C., 4. For facilities with a licensed capacity of 17 or more residents, a copy of the job description given to each staff member pursuant to rule 59A-36.010, F.A.C., 5. Documentation verifying direct care staff and administrator participation in resident elopement drills pursuant to paragraph 59A-36.007(8)(c), F.A.C. (b) The facility is not required to maintain personnel records for staff provided by a licensed staffing agency or staff employed by an entity ˙ ˙ ˙ ˙ ˙ ˙ ˙ ˙ ˙ ˙ ˙ to provide direct or indirect services to residents and the facility. However, the facility must maintain a copy of the contract between the facility and the staffing agency or contractor as described in rule 59A-36.010, F.A.C. (c) The facility must maintain the written work schedules and staff time sheets for the most current 6 months as required by rule 59A-36.010, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to maintain written work schedules for the most current six months as required by Rule 58A-5.019, Florida Administrative Code. (Photographic evidence obtained) Findings Included:	A 161		

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A 161	Continued From page 59 A review of the staffing schedule, conducted on , revealed that the staffing schedule provided by the Administrator was dated . The staffing schedule had the Administrator scheduled to work Mondays through Fridays from 08:00am through 06:00pm and Sundays from 09:00am through 01:00pm. The staffing schedule had Staff D scheduled to work Mondays and Fridays from 05:00pm through 09:00am and Wednesdays and Sundays from 05;00pm through 10:00pm. (Photographic evidence obtained) A review of the list of employees, conducted on , revealed that Staff D was not employed at the Facility. During an interview with the Administrator, conducted on at 11:30am, the Administrator stated that he was hospitalized from through and was not working at the Facility during that time. At 12:15pm, the Administrator agreed that the staffing schedule was not up to date and stated we just have the one master schedule. The Administrator stated Staff D doesn't work her and was terminated maybe two months ago. There was no other schedule provided. The Administrator was unable to identify who covered Staff D's shifts since the employee's termination. The Administrator was unable to identify who covered the Administrator's shifts when the Administrator was in the hospital from through . Class III	A 161		

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A 162	Continued From page 60	A 162		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. [illegible], 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance [illegible], 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, [illegible], or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A [illegible] record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their [illegible] recorded semi-annually.	A 162		

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A 162	Continued From page 61 (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S. (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , , ( ), CF-ES 1006, , , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the , , of a health care surrogate, health care proxy,	A 162		

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A 162	Continued From page 62 guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's [redacted], DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph, 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020,	A 162		

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A 162	Continued From page 63 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to maintain demographic data sheets and failed to obtain a -to- health assessments with all required data documented completely on the Agency for Health Care Administration's Form 1823 (1823) as required for three Residents (#2, #7, and #13) of three sampled residents. (Photographic evidence obtained) Findings Included: A record review for Resident #2, conducted on , revealed that there was no demographic data sheet for Resident #2. There was no date of Resident #2's admission into the Facility in the resident's record. (Photographic evidence obtained) A record review for Resident #7, conducted on , revealed that Resident #7's 1823 dated stated that Resident #7 required medication administration. A review of Resident #7's Medication Observation Records revealed that unlicensed Medication Technicians documented that they gave Resident #7 his medications every day. (Photographic evidence obtained) A record review for Resident #13, conducted on , revealed that Resident #13's 1823 dated was documented on form , and not on the form as required. Resident #13's 1823 had no assessment of the resident's and	A 162		

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A 162	Continued From page 64 behavioral status or the type of diet that Resident 13 required. The was no Examiner's printed name and the script name was illegible. There was no address or telephone number of the Examiner. (Photographic evidence obtained) A review of the Facility's list of employees, conducted on , revealed that the Facility did not employee a licensed nurse to administer medications. During an interview with the Administrator, conducted on at 11:30am, the Administrator agreed that Resident #2 had no demographic data sheet. The Administrator stated that Resident #7's 1823 was incorrect and that the resident required assistance with medications and not medication administration. The Administrator agreed that Resident #13's 1823 was not complete or on the correct form. Class III	A 162		
A 200 SS=G	59A-36.025 FAC Emergency Environmental Control 59A-36.025 Emergency Environmental Control for Assisted Living Facilities. (1) DETAILED EMERGENCY ENVIRONMENTAL CONTROL PLAN. Each assisted living facility shall prepare a detailed plan ("plan") to serve as a supplement to its Comprehensive Emergency Management Plan, to address emergency environmental control in the event of the loss of primary electrical power in that assisted living facility which includes the following information: (a) The acquisition of a sufficient alternate power source such as a generator(s), maintained at the assisted living facility, to ensure that current	A 200		

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A 200	Continued From page 65 licensees of assisted living facilities will be equipped to ensure air temperatures will be maintained at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. 1. The required temperature must be maintained in an area or areas, determined by the assisted living facility, of sufficient size to maintain residents safely at all times and that is appropriate for resident care needs and life safety requirements. For planning purposes, no less than twenty (20) net square per resident must be provided. The assisted living facility may use eighty percent (80%) of its licensed bed capacity as the number of residents to be used in the to determine the required square footage. This may include areas that are less than the entire assisted living facility if the assisted living facility's comprehensive emergency management plan includes allowing a resident to congregate when he or she desires in portions of the building where temperatures will be maintained and includes procedures for monitoring residents for signs of heat related injury as required by this rule. This rule does not prohibit a facility from acting as a receiving provider for evacuees when the conditions stated in section 408.821, F.S. and subsection 59A-36.019(5), F.A.C., are met. The plan shall include information regarding the area(s) within the assisted living facility where the required temperature will be maintained. 2. The alternate power source and fuel supply shall be located in an area(s) in accordance with local zoning and the Florida Building Code. 3. Each assisted living facility is unique in size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care	A 200		

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A 200	Continued From page 66 offered; and staffing characteristics. Accordingly, this rule does not limit the types of systems or equipment that may be used to achieve temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours in the event of the loss of primary electrical power. The plan shall include information regarding the systems and equipment that will be used by the assisted living facility and the fuel required to operate the systems and equipment. a. An assisted living facility in an evacuation zone pursuant to chapter 252, F, S. must maintain an alternative power source and fuel as required by this subsection at all times when the assisted living facility is occupied but is permitted to utilize a mobile generator(s) to enable portability if evacuation is necessary. b. Assisted living facilities located on a single campus with other facilities under common ownership, may share fuel, alternative power resources, and resident space available on the campus if such resources are sufficient to support the requirements of each facility's residents, as specified in this rule. Details regarding how resources will be shared and any necessary movement of residents must be clearly described in the emergency power plan. c. A multistory facility, whose comprehensive emergency management plan is to move residents to a higher floor during a flood or surge event, must place its alternative power source and all necessary additional equipment so it can safely operate in a location protected from flooding or storm surge damage. (b) The acquisition of sufficient fuel, and safe maintenance of that fuel at the facility, to ensure that in the event of the loss of primary electrical power there is sufficient fuel available for the alternate power source to maintain	A 200		

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	AL11942749	A. BUILDING: _____ B. WING _____	01/21/2021

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PICKET FENCE MANOR	1662 9TH STREET SOUTH SAINT PETERSBURG, FL 33701

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A 200	Continued From page 67 temperatures at or below 81 degrees Fahrenheit for a minimum of ninety-six (96) hours after the loss of primary electrical power during a declared state of emergency. The plan must include information regarding fuel source and fuel storage. 1. Facilities must store minimum amounts of fuel onsite as follows: a. A facility with a licensed capacity of 16 beds or less must store 48 hours of fuel onsite. b. A facility with a licensed capacity of 17 or more beds must store 72 hours of fuel onsite. 2. An assisted living facility located in an area in a declared state of emergency area pursuant to section 252.36, F.S. that may impact primary power delivery must secure ninety-six (96) hours of fuel. The assisted living facility may utilize portable fuel storage containers for the remaining fuel necessary for ninety-six (96) hours during the period of a declared state of emergency. 3. Piped natural gas is an allowable fuel source and meets the onsite fuel supply requirements under this rule. 4. If local ordinances or other regulations limit the amount of onsite fuel storage for the assisted living facility's location, then the assisted living facility must develop a plan that includes maximum onsite fuel storage allowable by the ordinance or regulation and a reliable method to obtain the maximum additional fuel at least 24 hours prior to depletion of onsite fuel. (c) The acquisition of services necessary to maintain, and test the equipment and its functions to ensure the safe and sufficient operation of the alternate power source maintained at the assisted living facility. (d) The acquisition and maintenance of a . . . . monoxide alarm. (2) SUBMISSION OF THE PLAN.	A 200		

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A 200	Continued From page 68 (a) Each assisted living facility licensed prior to the effective date of this rule shall submit its plan to the local emergency management agency for review within 30 days of the effective date of this rule. Assisted living facility plans previously submitted and approved pursuant to emergency Rule 58AER17-1 will require resubmission only if changes are made to the plan. (b) Each new assisted living facility shall submit the plan required under this rule prior to obtaining a license. (c) Each existing assisted living facility that undergoes any additions, modifications, alterations, refurbishment, renovations or reconstruction that require modification of its systems or equipment affecting the facility's compliance with this rule shall amend its plan and submit it to the local emergency management agency for review and approval. (3) APPROVED PLANS. (a) Each assisted living facility must maintain a copy of its approved plan in a manner that makes the plan readily available at the licensee's physical address for review by a legally authorized entity. If the plan is maintained in an electronic format, assisted living facility staff must be readily available to access and produce the plan. For purposes of this section, "readily available" means the ability to immediately produce the plan, either in electronic or paper format, upon request. (b) Within two (2) business days of the approval of the plan from the local emergency management agency, the assisted living facility shall submit in writing proof of the approval to the Agency for Health Care Administration. (c) The assisted living facility shall submit a consumer-friendly summary of the emergency power plan to the Agency. The Agency shall post	A 200		

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the summary and notice of the approval and implementation of the assisted living facility emergency power plans on its website within ten (10) business days of the plan's approval by the local emergency management agency and update within ten (10) business days of implementation.

(4) IMPLEMENTATION OF THE PLAN.

(a) Each assisted living facility licensed prior to the effective date of this rule shall, no later than [illegible], have implemented the plan required under this rule.

(b) The Agency shall allow an extension up to [illegible] to providers in compliance with paragraph (c) below and who can show delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes. Assisted living facilities shall notify the Agency that they will utilize the extension and keep the Agency apprised of progress on a quarterly basis to ensure there are no unnecessary delays. If an assisted living facility can show in its quarterly progress reports that unavoidable delays caused by necessary construction, delivery of ordered equipment, zoning or other regulatory approval processes will occur beyond the initial extension date, the assisted living facility may request a waiver pursuant to section 120.542, F.S.

(c) During the extension period, an assisted living facility must make arrangements pending full implementation of its plan that provides the residents with an area or areas to congregate that meets the safe indoor air temperature requirements of subsection (1) (a) for a minimum of ninety-six (96) hours.

1. An assisted living facility not located in an evacuation zone must either have an alternative power source onsite or have a contract in place

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

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A 200	Continued From page 71 maintain the alternate power source and any fuel required for the operation of the alternate power source. The procedures shall ensure that residents do not experience complications from fluctuations in air temperatures inside the facility. Procedures must address the care of residents occupying the facility during a declared state of emergency, specifically, a description of the methods to be used to mitigate the potential for heat related injury including: 1. The use of cooling devices and equipment; 2. The use of refrigeration and freezers to produce ice and appropriate temperatures for the maintenance of medicines requiring refrigeration; 3. Wellness checks by assisted living facility staff to monitor for signs of and heat injury; and 4. A provision for obtaining medical intervention from emergency services for residents whose life safety is in jeopardy. (b) Each assisted living facility shall maintain the written policies and procedures in a manner that makes them readily available at the licensee's physical address for review by a legally authorized entity. If the policies and procedures are maintained in an electronic format, assisted living facility staff must be readily available to access the policies and procedures and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce the policies and procedures, either in electronic or paper format, upon request. (c) The written policies and procedures must be readily available for inspection by each resident; each resident's legal representative, designee, surrogate, guardian, attorney in fact, or case manager; each resident's estate; and such additional parties as authorized in writing or by law.	A 200		

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A 200	Continued From page 72 (6) REVOCATION OF LICENSE, FINES OR SANCTIONS. For a violation of any part of this rule, the Agency for Health Care Administration may seek any remedy authorized by chapter 429, part I, or chapter 408, part II, F.S., including, but not limited to, license revocation, license suspension, and the imposition of administrative fines. (7) COMPREHENSIVE EMERGENCY MANAGEMENT PLAN. (a) Assisted living facilities whose comprehensive emergency management plan is to evacuate must comply with this rule. (b) Each facility whose plan has been approved shall submit the plan as an addendum with any future submissions for approval of its comprehensive emergency management plan. (8) NOTIFICATION. (a) Within five (5) business days, each assisted living facility must notify in writing, unless permission for electronic communication has been granted, each resident and the resident's legal representative: 1. Upon submission of the plan to the local emergency management agency that the plan has been submitted for review and approval; 2. Upon final implementation of the plan by the assisted living facility. (b) Each assisted living facility must maintain a copy of each notification set forth in paragraph (a) above in a manner that makes each notification readily available at the licensee's physical address for review by a legally authorized entity. If the notifications are maintained in an electronic format, facility staff must be readily available to access and produce the notifications. For purposes of this section, "readily available" means the ability to immediately produce the notifications, either in electronic or paper format,	A 200		

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A 200	Continued From page 73 upon request. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide proof that their emergency environmental control plan was implemented. Additionally, the facility failed to develop written policy and procedures to ensure that the facility could effectively and immediately operate the alternate power source. Furthermore, the facility failed to notify each resident and/or resident representatives in writing of the implementation of their environmental control plan. Findings Included: During an attempt to review the Facility's emergency environmental control plan, conducted on . . . . . , the emergency environmental control plan was not provided. During an attempt to review written policy and procedures that the Facility could effectively and immediately operate their alternate power source, conducted on . . . . . , there was no policy and procedure provided. During an attempt to review services acquired to test and maintain the alternate power source and fuel equipment, conducted on , there was no evidence that the Facility obtained services to test and maintain the alternate power source and fuel equipment. During an attempt to review notifications to residents and/or their representatives that the Facility implemented their emergency environmental control plan, conducted on , there was no evidence provided that the Facility notified residents and/or their	A 200		

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A 200	Continued From page 74 representatives that the Facility had implemented their emergency environmental control plan. During an interview with the county fire inspector (FI), conducted on at 01:05pm, the FI stated that the most recent comprehensive emergency management plan approval was . At 01:17pm, the FI stated that the Facility did not have any testing or maintenance logs for the generator and that the occupant load may be in violation. At 02:10pm, the FI stated that the Facility had not obtained testing for their fire sprinkle system. During an interview with the Administrator, conducted on at 01:30pm, the Administrator stated that the generator automatically tested every Monday at 12:00pm. The Administrator was unable to provide the testing logs. The Administrator agreed that there were no services obtained to perform general maintenance on the alternate power source equipment or fuel source equipment. The Administrator was unable to provide a written policy and procedures to show that the Facility could effectively and immediately operate their alternate power source. The Administrator was unable to provide evidence that each resident and/or their representatives were notified that the Facility had implemented their emergency environmental control plan. Class II	A 200		
A1300 SS=D	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:	A1300		

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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 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

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A1300	Continued From page 76 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 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;	A1300		

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A1300	Continued From page 77 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 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	A1300		

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A1300	Continued From page 78 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; 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 ,	A1300		

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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 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:

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(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
A1300	Continued From page 80 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 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;	A1300		

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	AL11942749	A. BUILDING: _____ B. WING _____	01/21/2021

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A1300	Continued From page 81 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. 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 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 , , , including , , chills, , , 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 with COVID-19, who does not meet the most recent criteria from the CDC to end , 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 mask. All facilities are encouraged to provide regular COVID-19 testing for staff and visitors. 4. Any resident leaving the facility temporarily for medical , , or other activities, and any resident receiving visits from health care	A1300		

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A1300	Continued From page 82 providers, must wear a . . . mask, if tolerated by that resident's condition. All residents must be screened upon return to the facility. . . protection should also be encouraged. . . . . should be scheduled through the facility or group home to ensure proper screening and adherence to . . . . . -control measures. 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 observation, record review, and interview, the Facility failed to comply with the visitation emergency order put in place to mitigate the transmission of COVID-19. Furthermore, the Facility failed to comply with the . . . . . control guidelines issued by the Centers for . .	A1300		

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A1300	Continued From page 83 Control (CDC) to mitigate the transmission of COVID-19. Findings Included: Observations, conducted on from 11:30am through 05:00pm, revealed that the Facility did not screen visitors at the Facility. There was no sign-in log for visitors. Visitors were allowed to move freely through the Facility and came and went from the Facility on their own accord without established visitation . . . . . All fourteen residents were at risk for illnesses associated with exposure to bio-growth, dust accumulation in air vents. Every room in the Facility was overcome with filth, dirt, dust, cigarette ashes, and pests such as bedbugs, roaches, fruit flies, and house flies. In many rooms, there were piles of dirty and foul-smelling clothing. There was dirty water mixed with . . . and feces on the floor of the first-floor bathroom that had a horrific stench from . . . and feces. None of the three bathrooms for resident use had soap or paper towels for . . . hygiene. The deplorable conditions in the Facility confirmed that the Facility was not cleaning and . . . . . frequently touched surfaces. Residents walked in and out of the small kitchen where Staff B and E were preparing the lunch meal and the area was not large enough to maintain social distancing. Residents and visitors came and went from the Facility freely. At no time did the staff screen staff, residents, or visitors for signs and symptoms of COVID-19. At no time during the survey did staff encourage social distancing among residents or encourage residents to wear . . . masks. Residents were observed congregating in the outside smoking area and in the dining room for the lunch meal. The mealtimes were not	A1300		

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A1300	Continued From page 84	A1300		

staggered to accommodate social distancing. There were no signs posted anywhere in the Facility related to control and prevention of COVID-19 with regards to proper use of personal protection equipment, hygiene, and social distancing. At 11:35am, a man identified as a homeless man was sleeping in the bed closest to the door in bedroom two. Resident #14 was sitting on the bed touching the homeless man. At 11:41am, there was food stuck on the wall, door, and door frame in the living room that appeared to be eggs and grits. At 12:00pm, Resident #2 was serving the lunch meal to the residents that had congregated in the dining room. At 12:10pm, Resident #3 was observed returning to the Facility through the dining room door. Staff B saw the resident and did not screen the resident. Resident #3's and were black and filthy with heavy dirt or grime under his . Staff B did not ask the Resident #3 to wash his . At 05:00pm, a delivery truck arrived to deliver new mattresses to the Facility. The two delivery personnel were not screened for signs and symptoms of COVID-19 upon entrance.

A review of the county health department's group care inspection reports dated and , conducted on , there were ten violations on each report.

A review of the Facility's policy and procedures, conducted on , revealed that the Facility did not have an control policy and procedures to mitigate the transmission of COVID-19 in the Facility. The Facility did not maintain visitor logs or schedule visits by . The Facility did not have screening logs in place for the screening of visitors, staff, or residents for signs and symptoms of COVID-19.

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A1300	Continued From page 85 During an interview with Staff B, conducted on [redacted] at 12:10pm, Staff B stated that Resident #3 often leaves the property to collect items from garbage dumpsters in the neighborhood. During an interview with Staff E, conducted on [redacted] at 11:41am, Staff E stated that a resident threw his breakfast plate of eggs and grits against the wall. At 03:07pm, Staff E stated that the cab driver hangs out and volunteers and helps with delivery of groceries. Staff E stated that the cab driver was not an employee or a resident at the Facility. During an interview with the Administrator, conducted on at 11:30am, the Administrator stated that he was hospitalized from through and that he was aware that everything was a mess. At 04:50pm, the Administrator agreed that the Facility did not have processes in place to mitigate the transmission of COVID-19. Class III	A1300		
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the [redacted] are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that	CZ814		

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CZ814	Continued From page 86 requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic , submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the Facility failed to maintain the employment status of staff members within the Facility's background screening employee roster listed in the Agency for Health Care Administration's background screening clearinghouse, within ten-business days of termination of employment for one (Staff C) of three sampled former employees. Findings Included: A review of the Facility's background screening employee roster, conducted on , revealed that Staff C continued on the Facility's background screening roster as a current employee. A review of the current Facility employees, conducted on , revealed that Staff C	CZ814		

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CZ814	Continued From page 87 was not listed as a current employee of the Facility. During an interview with the Administrator, conducted on at 4:50pm, the Administrator stated that Staff C was no longer employed by the Facility. The Administrator did not provide the requested termination dates for Staff C. Unclassified	CZ814		