

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964889	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/25/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARBOR COVE ALF OF FLORIDA INC

**305 NORTH HIAWASSEE RD
ORLANDO, FL 32835**

(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
CZ814 SS=C	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.- (b) Until such time as the _____ 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 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 review of the facility's online background clearinghouse employee roster, personnel record reviews and interview, the facility failed to update the employment status for 1 of 4 sampled staff (C) within 10 business days of a change. Findings:	CZ814		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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CZ814	Continued From page 1 Review of the facility's background clearinghouse employee roster at 1:32 p.m. on revealed that caregiver C was not listed. Review of the caregiver's personnel record revealed it did not contain a hire date and did contain an eligible background screening dated The administrator said the caregiver was hired on and upon reviewing the roster herself, confirmed the finding. (photographic evidence obtained). Review of the facility's staffing schedule revealed that caregiver C was scheduled to work on and The administrator confirmed the caregiver worked on those dates. Unclassified	CZ814		
A 000	Initial Comments A Relicensure survey, Control Monitoring and Generator Monitoring were conducted on Arbor Cove ALF of Florida had deficiencies at the time of the visit.	A 000		
A 008 SS=D	429.26() FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner ' s form or on a	A 008		

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A 008	Continued From page 2 form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes a permanent part of the facility's record of the resident and must be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental	A 008		

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A 008	Continued From page 3 health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or registered nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The	A 008			

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A 008	Continued From page 4 examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or _____ services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of _____ or any other communicable _____, which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, _____, which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170 , Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed.	A 008			

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A 008	Continued From page 5 - Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. - Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. - Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. - Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. - Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). - An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. - Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health	A 008		

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A 008	Continued From page 6 assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of _____ or _____ (g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the 1823 health assessment form was complete for 1 of 2 sampled residents (#1). Findings: Review of resident #1's most recent 1823, dated , revealed the question as to whether or not the resident was at risk for elopement was not answered. (photographic evidence obtained.). The resident's record did not contain documentation to indicate the facility contacted a health care provider to obtain the omitted information. At 2:45 p.m. on _____, the administrator	A 008		

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A 008	Continued From page 7 confirmed the finding and was unable to provide additional documentation. Class III	A 008		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of _____ or _____ or has a change of condition _____ in order to rule out the presence of an underlying physiological condition that may be contributing to such _____ or _____. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making _____ for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule	A 025		

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A 025	Continued From page 8 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to properly supervise 1 of 6 sampled residents (#6) who eloped from the facility. Findings: At 11:05 a.m. on _____, caregiver B said last week, unsure of exact date, she saw resident #6 sitting at the bus stop in front of the facility so she returned him to the facility. The resident said he was going to a drug store, located approximately 3 miles from the facility, to buy a cigar. He did not sign out and did not tell the caregiver he was leaving.	A 025			

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A 025	Continued From page 9 Review of the resident's record revealed a facility admission date of . His most recent 1823 health assessment form, dated, indicated that his diagnoses included (.) type 2, history of dependency, and a left He was forgetful and used a wheelchair for mobility. Review of facility notes revealed the following: at 2:30 p.m. - he had periods of at 11:30 a.m. - he left the facility and caregivers saw him at the bus stop and returned him to the facility. Covid precautions were reviewed with him. He had been and kept coming out of his room to smoke. at 2:15 p.m. - he was examined by a health care provider. He had episodes of incoherent thoughts stating "called the police for killing the child". at 2:15 p.m. - he was seen by a health care provider. He had episodes of inappropriate thought processes, was socializing less with the other residents and mostly stayed in his room, only coming out to smoke. was prescribed. 3:45 p.m. - he was seen by a health care provider. He remained at 10:33 a.m. - night caregivers reported resident had been awake all night and going outside to smoke. A health care provider was notified of the concern and adjusted his	A 025		

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A 025	Continued From page 10 medications. at 12:43 p.m. - he went out to the mailbox then attempted to go to the store. At 1:10 p.m., he was examined by a health care provider and afterwards he made another attempt to leave. He was found on the sidewalk and brought to the facility. At 5:15 p.m. he was reminded to stay in the facility due to Covid and offered assistance to purchase items he needed from the store. He continued to receive reorientation due to his and forgetfulness. A health care provider ordered - a health care provider prescribed (medication). at 5:10 p.m. - caregivers reported he was absent from the facility and could not be located following a search. He was last seen at the facility twenty minutes prior. At 6:03 p.m., the facility owner found him across a three lane highway located approximately 2 miles from the facility. He was reminded of safety and Covid precautions and returned to the facility. At 6:35 p.m., a health care provider was notified of the event and an episode in which he called the police to report the killing of a baby. His medications were reviewed and adjusted. - initial evaluation by a psychiatrist contained documentation that indicated staff reported a problem with the resident leaving the facility and , a time in which he was found at a gas station, and another in which it took an hour for him to agree to return to the facility. at 3:53 p.m. - a caregiver reported that he could not be found and was last seen smoking	A 025		

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A 025	Continued From page 11 on the front porch at 3 p.m. At 6:20 p.m., the search continued without success. At 7:30 p.m., law enforcement was contacted for assistance. At 8 p.m., law enforcement was provided with a photo, medical history and were informed that three weeks prior he said he wanted to be homeless, as he had been in the past. at 8 a.m. - the facility continued its search for the resident in neighboring areas without success. At 4:07 p.m., law enforcement called to report finding him approximately 9 miles from the facility. At 4:55 p.m., the owner returned him to the facility; he was in his wheelchair when found. He did not sustain any injuries. A health care provider was notified and his medication was adjusted. at 12:45 p.m. - he left the facility on the previous Sunday and had to be returned by a caregiver. He was reminded of Covid precautions and concern for the other residents. At 1:15 p.m. on, the administrator said she was not concerned about the resident's safety each time he left the facility because she believed he would find his way and said the only reason she continued to have him brought was because she did not want him to contract Covid and bring it into the facility. She said there were no attempts made to find him alternate placement and repeated that she believed the resident was safe to go to the store alone but she did not want him to do so due to Covid. At 1:45 p.m. on, caregiver G described a weekend event that occurred at 5 a.m., he could not remember the date, in which the resident requested coffee but when the caregiver took it to	A 025		

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A 025	Continued From page 12 the resident, he was gone. The caregiver walked outside to look for him and found him in his wheelchair going towards a drug store. The caregiver returned the resident to the facility and did not see any injuries on him. At 2:04 p.m. on _____, the resident said he got bored so he left the facility without telling anyone or signing out. When asked his planned destinations he replied "just nowhere". When asked about leaving on _____, he said he did not remember that. At 2:34 p.m. on _____, caregiver A said on _____ she last saw the resident at 2 p.m. and noticed him missing at approximately 3 p.m. The resident did not tell her he was leaving. She searched inside and outside of the facility but was unable to locate him. She then called the owner. At 3:49 p.m. on _____, the owner said that on _____ at approximately 3:30 p.m. the staff reported to him that the resident was missing. He joined the search at 6:20 p.m. then called law enforcement at 7:30 p.m. Documentation in the resident's record indicated that he left the facility without knowledge of the staff and without signing out on three different occasions prior to a fourth absence in which he was found by law enforcement approximately 9 miles from the facility. His medical history, including diagnoses of _____ and _____, his _____, forgetfulness, _____ and use of a wheelchair for mobility all placed him at a greater risk for harm. Although medication changes and resident reminders were done, the facility's failure to provide adequate supervision allowed him to repeatedly elope from the facility.	A 025		

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A 025	Continued From page 13 Class II	A 025		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2) (a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to	A 032		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964889	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/25/2021
NAME OF PROVIDER OR SUPPLIER ARBOR COVE ALF OF FLORIDA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 305 NORTH HIAWASSEE RD ORLANDO, FL 32835		
(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 032	Continued From page 14 admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to make a daily effort to ensure 1 of 1 sampled resident (#6) identified as an elopement risk, had identification (ID) on their person that included their name and the facility's name, address, and telephone number. Findings: Review of the resident #6's record revealed a facility admission date of . His most	A 032			

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A 032	Continued From page 15 recent 1823 health assessment form, dated _____, indicated that his diagnoses included _____ (_____, _____) type 2 _____, history of _____ dependency and he had a left _____. He was forgetful and used a wheelchair for mobility. Review of the resident's record revealed that on _____, he could not be located at or around the facility. Law enforcement was called to assist with the search and found him the next day on _____ located approximately 9 miles away from the facility. At 2:04 p.m. on _____, when asked about the event on _____, the resident said he did not remember it. At 2:40 p.m. on _____, the administrator spoke with the resident and checked to see whether the resident had ID on his person that included his name and the facility's name, address and telephone number. He did not. The administrator was unable to provide documentation to indicate a daily effort was made to ensure he did have ID in case he left the facility again. Class III	A 032		
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	A 078		

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A 078	Continued From page 16 of communicable The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (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	A 078		

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A 078	Continued From page 17 requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on personnel record reviews and interview, the facility failed to ensure the personnel record for 1 of 3 sampled staff (administrator) contained documented evidence of a negative exam on an annual basis. Findings: Review of the administrator's personnel record revealed a hire date of . The record contained a negative exam, dated , and did not contain one annually thereafter. (photographic evidence obtained). At 3:15 p.m. on , the administrator confirmed the finding and said she did not have a exam since . Class III	A 078		

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A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: <table border="0"> <tr> <td>Number of Residents, Day Care Participants, and Respite Care Residents</td> <td>Staff Hours/Week</td> </tr> <tr> <td>0-5</td> <td>168</td> </tr> <tr> <td>16-25</td> <td>212</td> </tr> <tr> <td>26-35</td> <td>253</td> </tr> <tr> <td>36-45</td> <td>294</td> </tr> <tr> <td>46-55</td> <td>335</td> </tr> <tr> <td>56-65</td> <td>375</td> </tr> <tr> <td>66-75</td> <td>416</td> </tr> <tr> <td>76-85</td> <td>457</td> </tr> <tr> <td>86-95</td> <td>498</td> </tr> <tr> <td></td> <td>539</td> </tr> </table> For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all	Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week	0-5	168	16-25	212	26-35	253	36-45	294	46-55	335	56-65	375	66-75	416	76-85	457	86-95	498		539	A 079		
Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week																									
0-5	168																									
16-25	212																									
26-35	253																									
36-45	294																									
46-55	335																									
56-65	375																									
66-75	416																									
76-85	457																									
86-95	498																									
	539																									

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A 079	Continued From page 19 hours of the day and night. 5. 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 of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least . must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant	A 079		

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A 079	Continued From page 20 positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission	A 079		

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A 079	Continued From page 21 of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern for a given time period. Findings: At 1:57 p.m. on _____, a request was made to review the facility's _____ staffing schedule. The facility's owner said only _____ was available because past schedules were not maintained.	A 079		

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A 079	Continued From page 22	A 079		
	Class III			
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 _____; 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 _____. (c) A log listing the names of all temporary emergency placement and respite care residents	A 160		

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A 160	Continued From page 23 if not included on the log described in paragraph (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.	A 160		

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A 160	Continued From page 24 (m) Pursuant to section 429.35, F.S., all 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 record review and interview, the facility failed to maintain an annual satisfactory fire inspection. Findings: Review of the facility's most recent satisfactory fire inspection revealed it was dated Review of a fire inspection, dated, revealed the facility failed the inspection and corrections were required. (photographic evidence obtained). At 11:35 a.m. on, the administrator confirmed the findings, said the corrections were made, and that a revisit by the fire marshall had not yet been done. Class III	A 160		

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A 165 SS=D	Continued From page 25 429.23(&) FS; 59A-36.016 FAC Risk Mgmt & QA; Adverse Incident Report 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident 's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident 's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1	A 165 A 165		

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STREET ADDRESS, CITY, STATE, ZIP CODE

ARBOR COVE ALF OF FLORIDA INC

**305 NORTH HIAWASSEE RD
ORLANDO, FL 32835**

(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 165	Continued From page 26 business day after the occurrence of an adverse incident, through the agency ' s online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility ' s investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency ' s online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility ' s investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or	A 165		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964889	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/25/2021
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A 165	Continued From page 27 through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. 59A-36.016 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1), above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to submit to the agency, a preliminary adverse incident report within 1 business day and a full report within 15 days of a resident elopement and an event that was reported to law enforcement for investigation. Findings:	A 165		

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A 165	Continued From page 28 Review of the resident #6's record revealed a facility admission date of . His most recent 1823 health assessment form, dated , indicated that his diagnoses included () type 2 , history of , dependency, and a left . He was forgetful and used a wheelchair for mobility. Facility notes revealed that on , he could not be located at or around the facility. Law enforcement was called to assist with the search and found him on located approximately 9 miles away from the facility. Review of the facility's adverse incident report of the event revealed a preliminary report was submitted on , however, it indicated only that an event was reported to law enforcement and did not also indicate a resident elopement. In addition, the agency closed the full report on because requested information was not received from the provider. (photographic evidence obtained). At 1:15 p.m. on , the owner said he did submit everything but neither he nor the administrator could provide additional documentation to indicate that. Class III	A 165			
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	A1300			

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A1300	Continued From page 29 following circumstances: A. Family members, friends, and individuals visiting residents in end-of-life situations including any resident enrolled in hospice; B. Hospice or _____ care workers caring for residents in end-of-life situations including any resident enrolled in hospice; C. Any individuals or providers giving necessary health care to a resident, provided that 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	A1300		

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A1300	Continued From page 30 the Department of Children and Families, the Department of Health, the Department of Elderly Affairs, the Agency for Health Care Administration, the Agency for Persons with Disabilities, 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 provide prevention and control education, including education on proper use of PPE, hand hygiene, and social distancing; 5. Designate key staff to support prevention and control training; 6. Screen compassionate care visitors to	A1300		

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A1300	Continued From page 31 prevent possible introduction of COVID-19; 7. Maintain a visitor log for signing in and out; 8. Monitor visitor adherence to appropriate use of masks, PPE, and social distancing, especially for those who may have difficulty with compliance such as children; and 9. After attempts to mitigate concerns, restrict or revoke visitation if the compassionate 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 feet 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. J. 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	A1300			

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A1300	Continued From page 32 compassionate care visitors, under the criteria detailed below: i. To accept general visitors, the facility must meet the following criteria: 1. Other than in a dedicated wing or unit that accepts COVID-19 cases from the community, the facility must have no new facility-onset of resident COVID-19 cases in the previous fourteen (14) days; 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 feet 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	A1300		

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A1300	Continued From page 33 resident receiving general visitors is _____, positive for COVID-19 and not recovered (as defined by most recent CDC guidance), or _____ for COVID-19; 2. Screen general visitors to prevent possible introduction of COVID-19; 3. Establish limits on the total number of visitors allowed in the facility, or with a resident at one time based on the ability of staff to safely 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	A1300		

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A1300	Continued From page 34 both paragraphs 1 and 2 below: 1. Provide outdoor visitation spaces that are protected from weather elements, such as porches, courtyards, patios, or other covered areas that are protected from heat and sun, with cooling devices if needed. The provisions of K.(i) (1) and (2) are not applicable to outdoor visitation. 2. Create indoor visitation spaces for residents in a room that is not accessible by other 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	A1300			

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A1300	Continued From page 35 residents, not outside clients or guests; vi. Services may not be provided to a resident who tests positive for COVID-19 or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19; and vii. Service and salon areas must be properly cleaned and _____, and equipment must be sanitized between residents. 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	A1300		

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A1300	Continued From page 36 resident receiving visits from health care 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 observations, record review and interview, the facility failed to safe guard 10 residents' well-being by failing to follow current control standards related to COVID-19 and Florida Governor's emergency order DEM	A1300		

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A1300	Continued From page 37 Order 20-011, dated _____, delineating minimum screening standards for persons entering identified residential facilities. Findings: "The COVID-19 _____ is a transmissible _____ that presents severe risk to persons who are aged, infirm, or suffer from co-_____ including, but not limited to, _____ system deficiency, _____, and _____. See generally, Publications of the Centers for _____ Control." "On _____, the Governor of the State of Florida issued Executive Order 20-51 designating a Public Health Emergency as a result of COVID-19 and its impact. Pursuant to that authority, emergency orders have been issued by the Florida Division of Emergency Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizenry, including those most _____ to the effects of _____. Among those emergency orders was DEM Order 20-011, dated _____, delineating minimum screening standards for persons entering identified residential facilities." "The Agency for Health Care Administration (AHCA) has issued guidance and clarification on DEM Order 20-006 to providers, and on _____ issued an alert notifying nursing homes that all staff or other individuals admitted to a residential facility must don _____ masks and that caregivers must wear gloves when providing resident care. While the treatment and management of residents with _____ and the implementation of isolation precautions for such events are a long-standing health care	A1300		

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A1300	Continued From page 38 issues faced by residential facilities, the ease of contagion and the effects of _____ presented by COVID-19 mandate that providers exert meticulous practice and procedure to identify resident symptoms and take immediate _____ procedures to both assure appropriate treatment of a potentially _____ resident and protect the remainder of a facility's population from the risk of spread of the _____. At 9 a.m. on _____, both caregivers A and B were seen in the facility providing resident care. At 3:39 p.m. on _____, a request was made to review the facility's completed Covid-19 screenings. Review of them revealed there was not one for caregivers A and B. The administrator confirmed the findings and said only staff's temperature was taken at the beginning of each shift and additional screening was not conducted. At 3:44 p.m. on _____, a request was made to review the facility's visitation policy and procedure. The administrator said one was not created. In addition, review of the visitor sign-in log revealed resident #7's family member visited on _____. A request was made to review an acknowledgement form signed by the visitor noting receipt and understanding of just the facility's _____ prevention and control policies, since the facility did not have a visitation policy. However, the administrator said the visitor did not sign such a document. Class III	A1300		