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
	AL11969626	A. BUILDING: _____ B. WING _____	02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRIVE AT FERN PARK	7255 STRIVE PL FERN PARK, FL 32730

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Complaint Investigation #2021002153 and [redacted] Control Monitoring were conducted on [redacted] and [redacted]. Strive at Fern Park had deficiencies at the time of the visit.	A 000		
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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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 1 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 observations, record reviews and interviews, the facility failed to provide adequate supervision to 2 of 3 sampled residents, both of whom eloped from the facility (#1 & 2). Findings: 1. Review of a facility adverse incident report (AIR) dated , revealed resident #1 eloped from the facility on at approximately 9:20 a.m. On at 10:31 a.m., nurse A said she received a call from one of the caregivers at approximately 9:30 a.m. asking her to come to	A 025		

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A 025	Continued From page 2 the Memory Care unit. She then learned that resident #1 could not be found on the unit. She instructed the staff to conduct a search of the unit, told the kitchen staff to search the assisted living side and common areas, told the owner of the situation, then told dietary staff to conduct a search by car. The nurse and the business office manager searched by outside. While outside, she called the facility for an update, then told staff to call 911. While she was walking to the facility, she learned the resident had been found at a store located approximately one mile from the facility. The road that led to the location was a six lane major thoroughfare. The resident was evaluated by emergency medical services ( ) at the location. The resident did not have any visible injuries, and was then returned to the facility. The staff were instructed to check on him every 30 minutes when he was in his room and to have him within sight when out of his room. The nurse said the staff, including herself, carry facility phones on them, and if an exit door is pushed, an alert goes to the phones. She said she did not receive an alert on her phone when the resident eloped. On at 10:48 a.m., the maintenance director said when resident #1 eloped, he reviewed camera footage and was able to determine the resident left the facility at approximately 9:15 a.m. He said the door the resident exited from had a 15-second delayed magnetic lock release. He checked the door on the same day of the elopement, found it to be functioning properly, and said an alert was sent to the staff phones when he tested the door. Previously he installed ring cameras inside the unit and near the doors. However, resident #1 was not seen on that camera when reviewed on the day of the elopement. An electric company	A 025		

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A 025	Continued From page 3 went to the facility on . . . . , reset the delay to 30 seconds and determined the alarms functioned properly. In addition, the facility added a function to be able to store data of when an alarm is sent to the phones so additional monitoring could be done. On at 1:09 p.m., the administrator and maintenance supervisor identified the door used by the resident to exit the unit. The door led to a service hallway that had two unsecured doors. One door led to the lobby and the other to the . . . parking lot. They both believed the resident left via the parking lot exit. They said the electric company was going to obtain permits to install alarms on those two doors. In addition, a large sticker of a bookcase was placed on the inside of the Memory Care unit door to deter residents from exiting through it. On . . . . at 1:33 p.m., caregiver C said she was informed by another employee that resident #1 could not be found in the unit on . . . . . She said she last saw him at approximately 9:30 a.m. walking around the unit. She did not hear a door alarm and did not receive an alert on her phone. When the resident was returned to the facility, she was instructed to check on him at least every 15-30 minutes. On . . . at 1:46 p.m., the owner said the nurse informed her that resident #1 was missing on . . . . . When the resident was seen on the outside camera, 911 was called. She and the nurse picked him up from a local store. She said staff were instructed to check on him every 15 minutes. She believed he followed someone out of the unit and said following his elopement, cameras were reviewed, the doors were tested, staff were interviewed, an electric company was	A 025		

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A 025	Continued From page 4 called, and the frequency of safety checks on the residents was increased. On at 2:12 p.m., caregiver D said at approximately 10:15 a.m. on the day of resident #1's elopement, she was giving another resident a bath when resident #1 walked into the room. She instructed him to leave. Afterwards, she could not find him and began searching the unit. She said she did not hear a door alarm and did not receive an alert on her phone. Review of resident #1's record revealed he was admitted to the facility on . His 1823 health assessment form, dated , included diagnosis of with , behavior. Special precautions indicated he was an exit-seeker and an elopement risk. Review of facility notes revealed the following: On at 12:18 a.m,. he was exit-seeking. On at 9:08 p.m., he was exit-seeking but responded to redirection. On at 9 p.m., he was exit-seeking but responded to redirection. On at 4:45 a.m., he was exit-seeking; he attempted to exit a door, the alarm sounded and staff redirected him to his room. On at 1:09 a.m., he had increased agitation and increased exit-seeking behavior. On at 9:20 a.m., staff alerted the nurse at 9:30 a.m. that resident #1 could not be located. The nurse told the staff to check every room on the unit. Kitchen staff were alerted to check every room on the assisted living side and the front lobby. The business office manager, activities director, dietary manager, marketer and facility owner were instructed to check local stores within a five mile . The receptionist called 911 at 10:15 a.m. on . The resident was located	A 025		

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A 025	Continued From page 5	A 025		

by local authorities at 11 a.m. on . . . at a local store approximately one mile from the facility. The facility owner and nurse responded to the location. was on the scene and assessed him. He had no injuries. He was taken to the facility. Staff were instructed to check on him every 30 minutes.

2. Review of a facility AIR, dated . . . . . , revealed resident #2 eloped from the facility on . . . . . at approximately 2:15 p.m.

On . . . . at 10:48 a.m., the maintenance director said at the time of the resident's elopement, the alarm on the door was set for a 15-second delay, so it was increased to 30 seconds. In addition, a function was installed that would send an alert to the facility phones anytime the door alarm was triggered.

On . . . . at 11:42 a.m., nurse A said when resident #2 eloped, she was alerted by staff that the resident could not be located. The facility was searched. She rode around with a sheriff's deputy to try and locate the resident, who was later found when an old neighbor of hers called 911 to report a woman at her door who was asking for help with finding her own home. The nurse and deputy arrived to the location and found the resident soaking wet from rain. She had a on her arm and . , and said she . while crossing the road. She was returned to the facility, then sent to the hospital based on a health care provider's instructions.

On at 1:09 p.m., the administrator and maintenance supervisor identified the door used by the resident to exit the unit. The door led to a service hallway that had two unsecured doors; one led to the lobby and the other to the

Agency for Health Care Administration

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A 025	Continued From page 6 parking lot. They both believed the resident left via the parking lot exit. On at 1:46 p.m., the facility's owner said following resident #2's elopement, the compnay who installed the door alarm went to the facility and determined it worked properly. She said the delay time was increased from a 15 to a 30-second delay and a function was added for an alert to be sent to the facility phones anytime the alarm went off. Review of resident #2's record revealed a facility admission date of . Her admission 1823 assessment, dated , indicated her diagnoses included . She was oriented only to self and was not identified as an elopement risk at that time. Review of facility notes revealed the following: On at 10:33 a.m., she was observed outside of the facility attempting to catch a ride. She was very and agitated. She refused to return to the facility, yelled, screamed and hit staff with her fists and walker. She said she was going home, wanted out of the facility, and was trying to catch a cab to her home. She eventually agreed to return to the facility then was placed inside the secured Memory Care unit for her safety. Family was notified and agreed with a move to the Memory Care unit. On at 2:24 p.m., the nurse was called to Memory Care unit because the resident could not be located. Every resident room, bathrooms, courtyard and outside parameter were checked. The executive director drove up and down a nearby highway, the maintenance director checked the security cameras, the chef checked the parking lot, and other staff checked local	A 025		

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A 025	Continued From page 7 stores and restaurants. The resident was seen on the camera in the parking lot near the dumpsters at 2:18 p.m. At 2:52 p.m., the receptionist notified local authorities. A picture of the resident and demographic information was provided to law enforcement. At 3:15 p.m., the nurse accompanied a law enforcement officer to continue the search. An old neighbor of the resident's called 911 to report a woman at her house who was asking for help in locating her own house. The location was a condominium in a neighboring city located approximately 4 miles from the facility. At 3:34 p.m., the nurse and officer made contact with the resident, who was seated in the of a police car. She was soaking wet and had a on her right and right and a on her arm. She stated she trying to cross the road. At 3:53 p.m., the resident was returned to the facility where emergency services evaluated her, then transported her to the hospital. At at 1:23 a.m., she returned to the facility. Both residents #1 and #2 lived in the secured Memory Care unit. Both had diagnosis of , and both exhibited exit-seeking behavior prior to the actual elopements. The facility's inadequate supervision and subsequent resident elopements directly threatened the physical and emotional health, safety, and security of both residents. Class II	A 025		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS.	A 032		

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A 032	Continued From page 8 (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 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	A 032		

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A 032	Continued From page 9 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)(i), 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 2 sampled resident who was identified as an elopement risk, had identification (ID) on their person that included their name and the facility's name, address, and telephone number (#1). Findings: Review of resident #1's 1823 health assessment form, dated , indicated that his diagnoses included with , behavior. Special precautions indicated he exit-seeked and was an elopement risk. Observations made on at 1:55 p.m. revealed the facility's owner checked to see if	A 032		

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A 032	Continued From page 10 resident #1 had ID on his person, which he did not. The owner said the resident always removed it. Review of the resident's record did not reveal any documentation to indicate the resident ever removed ID and that the facility continued to make a daily effort to ensure the ID was present. On at 2:15 p.m., the administrator confirmed the findings and said she was unable to provide any additional documentation. Class III	A 032		
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: 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	A1300		

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A1300	Continued From page 11	A1300		

facilities for court-related matters if virtual or telephonic means are unavailable;

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

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

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

J. Compassionate care visitors who meet the 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,

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A1300	Continued From page 12	A1300		

the facility shall:

1. Establish policies and procedures for designation and utilizations of compassionate care visitors;

2. Set a limit on the total number of visitors allowed in the facility based on the ability of staff to safely screen and monitor visitation;

3. Develop an agreeable schedule in concert with the residents and visitors, including evening and weekends, to accommodate work or childcare barriers;

4. Provide instructional signage throughout the facility and prevention and control education, including education on proper use of PPE, hygiene, and social distancing;

5. Designate key staff to support prevention and control training;

6. Screen compassionate care visitors to prevent possible introduction ofCOVID-19;

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

8. Monitor visitor adherence to appropriate use of masks, PPE, and social distancing, especially for those who may have difficulty with compliance such as children; and

9. After attempts to mitigate concerns, restrict or revoke visitation if the compassionate 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

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A1300	Continued From page 13	A1300		

distancing, and sign acknowledgement of completion of training and adherence to the facility's prevention and control policies;

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

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

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

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

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

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

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

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

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
	AL11969626	A. BUILDING: _____ B. WING _____	02/11/2021

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A1300	Continued From page 14 6. Adequate capacity at referral hospitals for the facility. ii. General visitors must: 1. Wear a mask and perform proper hygiene; 2. Sign an acknowledgement form noting receipt and understanding of the facility's visitation and prevention and control policies. 3. Comply with facility-provided COVID-19 testing, if offered; 4. Visit in a resident's room or other facility-designated area; and 5. Maintain social distance of at least six with staff and residents, and limit movement in the facility. iii. Before allowing general visitors, the facility shall: 1. Set a policy to prohibit visitation if the resident receiving general visitors is , , positive for COVID-19 and not recovered (as defined by most recent CDC guidance), or for COVID-19; 2. Screen general visitors to prevent possible introduction of COVID-19; 3. Establish limits on the total number of visitors allowed in the facility, or with a resident at one time based on the ability of staff to safely 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	A1300		

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A1300	Continued From page 15	A1300		

exhibiting symptoms indicating that he or she is presumptively positive for COVID-19, or a staff person who was in the facility in the prior ten (10) days tests positive for COVID-19;

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

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

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

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

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

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

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

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A1300	Continued From page 16	A1300		

precautions:
i. Services are permissible only if:
1. Other than in a dedicated wing or unit that accepts COVID-19 cases, the facility has had no new facility- onset of resident COVID-19 cases in the previous fourteen (14) days; and
2. Fourteen (14) days have passed with no new staff COVID-19 cases where a positive staff person was in the facility in the ten (10) days prior to the positive test.
ii. Barbers and salon staff must wear surgical masks, gloves, practice proper hygiene, and follow the same requirements as compassionate caregivers;
iii. Waiting customers must follow social distancing guidelines;
. Residents receiving services must wear masks;
v. Services are only provided to facility residents, not outside clients or guests;
vi. Services may not be provided to a resident who tests positive for COVID-19 or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19; and
vii. Service and salon areas must be properly cleaned and , and equipment must be sanitized between residents.

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, ,

Agency for Health Care Administration

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A1300	Continued From page 17 , 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 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	A1300		

Agency for Health Care Administration

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A1300	Continued From page 18	A1300		

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 reviews and interviews, the facility failed to safe guard 55 residents' well-being by failing to follow current control standards related to COVID-19 and Florida Governor's emergency orders DEM 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

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A1300	Continued From page 19 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 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 . On at 3:30 p.m., a review of the facility's visitation log revealed resident #3's family visited on . A request was made to review the visitor's COVID-19 screening and acknowledgement form signed by the visitor, noting receipt and understanding of the facility's visitation and prevention and control policies. The business office manager (BOM) said since the visit was considered an outside visit, the facility did not conduct a	A1300		

Agency for Health Care Administration

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A1300	Continued From page 20 COVID-19 screening. She then proceeded to show the surveyor where and how the visitation took place. A table was placed between an open doorway located in the lobby. The visitor sat on the side that was positioned outside and the resident on the other side, which was positioned inside. A barrier of any kind was not used, resulting in shared air. In addition, the BOM was unable to provide the requested acknowledgement form. Class III	A1300		