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
	AL11953519	A. BUILDING: _____ B. WING _____	02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CARE COTTAGE	2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952

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A 000	Initial Comments A Focused Control survey was conducted at Paradise Care Cottage Assisted Living Facility from through . The facility had deficiencies at the time of the survey.	A 000		
A 030	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents	A 030		

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A 030	Continued From page 1 and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section	A 030		

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A 030	Continued From page 2 429.41(1)(k), F.S., the use of physical . . . . . by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community.	A 030		

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A 030	Continued From page 3	A 030		

(f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a room with his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care [illegible], and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for

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A 030	Continued From page 4 relocation must be set forth in writing and provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the	A 030		

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A 030	Continued From page 5 complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder . . . . Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated . . . , . . . or . . . , ... under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a safe and healthy living environment as evidenced by failing to follow the Center for . . . . . Control and Prevention (CDC) control guidance to mitigate the spread of COVID-19, by failing to consistently conduct staff screening upon entry to	A 030		

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A 030	Continued From page 6 the facility to ensure staff were free from signs and symptoms of COVID-19. This failure put the 34 residents residing in the facility at risk for the potential for the COVID-19 . The findings included: Review of ongoing CDC.gov Interim Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus 2019 (COVID-19) Pandemic guidance on revealed the following: Recommended routine prevention and control practices during the COVID-19 pandemic includes establishing a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed SARS-CoV-2 and that they are practicing source control. Options could include (but are not limited to) individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, people report absence of and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 in the prior 10 days, and confirm they have not been exposed to others with SARS-CoV-2 during the prior 14 days. Review of the facility's Control Policies and Procedures COVID 19, documented as updated on , states in part, 'The ALF has developed and implemented control practices that conform to Agency for Health Care Administration (AHCA) regulations, CDC guidelines, federal, state and local regulations and currently accepted standards of practice. The ALF staff is assigned responsibility for the management of prevention and control	A 030		

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A 030	Continued From page 7 activities.' Further, documentation states the facility ' Control Plan establishes policies and procedures for controlling employee exposure to COVID-19. These policies and procedures include: Identifies all those residents and employees at risk for exposure to COVID-19; Provides record keeping in accordance with regulations; Monitors staff adherence to recommended policies, procedures and protective measures; Screen staff as required by law and regulation for exposure to COVID-19'. On at 1:00 PM, an interview was conducted with the Assistant Administrator who was asked how staff are being screened for the COVID-19 . The Assistant Administrator stated, staff are screened daily for increased temperature, signs and symptoms of the , and possible exposure, and explained a manual is kept at the time clock. The Assistant Administrator took the surveyor from the front entrance, through part of the dining area, to the time clock, which was centrally located in the building next to the medication room. The staff screening manual and a held thermometer were located at the time clock. Upon entering the building, staff would either have to walk through the lobby and dining room, or alternately walk through a resident room hallway in order to get to the time clock for self screening. Review of the staff screening manual compared to the staff schedule for the current week of through , revealed only 22 documented staff screenings were completed out of a possible 40 opportunities. Review of the staff screening forms dated , the day of the survey, revealed only the housekeeper and Assistant Administrator were screened. The Medication Technician Supervisor, two Resident	A 030		

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A 030	Continued From page 8 Aides Staff A and Staff B, and the Cook failed to be screened for the COVID-19 on the day of the survey. During this review with the Assistant Administrator, Staff A, was asked why she did not screen for the COVID-19 this morning. Staff A stated she did take her temperature but forgot to document it. There was no evidence of any oversight by the facility to monitor or ensure staff were adhering to the facility's policy, procedures and protective measures or were being consistently screened for signs and symptoms of COVID-19 prior to their shift beginning and having direct care contact with residents and other staff members. Class III	A 030		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . . . . 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	A 078		

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A 078	Continued From page 9 individual with a positive . . . . . test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable . . . . . . (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must 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.	A 078		

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A 078	Continued From page 10 (f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to receive a written statement from a health care provider for 3 of 5 sampled staff members, Staff A, Staff B and Staff C who had confirmed positive COVID-19 results to determine each staff member did not constitute a risk of transmitting this communicable before returning to work in the facility. The findings included: Review of the Centers for Control and Prevention (CDC) COVID-19 guidance from CDC.gov website Frequently Asked Questions(FAQs) Basics, documented the following on : COVID-19 is a , illness that can spread from person to person. There are many types of human coronaviruses, including some that commonly cause mild upper- , tract illnesses. An individual who is actively sick with COVID-19 can spread the illness to others. It's recommended that these individuals be either in the hospital or at home (depending on how sick they are) until they are better and no longer pose a risk of others. The duration of when someone is actively sick can vary. The decision on when to release someone from isolation must be made on a case-by-case basis in consultation with physicians, prevention and control experts, and public health officials. These health professionals will consider specifics of each person including	A 078		

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A 078	Continued From page 11 severity, illness signs and symptoms, and results of laboratory testing for each individual. Review of the facility's Control Policies and Procedures COVID-19 documented updated on , states in part, 'The ALF has developed and implemented control practices that conform to the Agency for Health Care Administration (AHCA) regulations, CDC guidelines, federal, state and local regulations and currently accepted standards of practice. The ALF staff is assigned responsibility for the management of prevention and control activities.' Review of the facility records revealed, there were no staff member COVID-19 screenings recorded as conducted from to . Further review of the facility records revealed, there were no COVID-19 testing results for its staff members from to . An interview was conducted with the Administrator on at 2:10 PM, who stated the facility did not have all of the facility staff member's COVID-19 testing results or documentation from , which was done by the laboratory arranged by the Department of Health. An interview was conducted with the Administrator on at 4:15 PM, who stated there were 3 staff members who tested positive for COVID-19 in , . She stated Staff C, who was the cook, became COVID-19 positive on or about , was immediately removed from duty at the facility and also became extremely sick with severe , , symptoms as a result of his COVID-19 . She stated	A 078		

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A 078	Continued From page 12 Staff C returned to work approximately 2 and a half weeks after being . She stated Staff A, the Medication Technician Supervisor and Staff B, a Medication Technician, became COVID-19 positive on or about , and were immediately removed from duty in the facility and were both . She stated Staff A and Staff B both returned to work after 10 days without symptoms. She confirmed the facility did not require a subsequent COVID-19 negative test result or a physician health statement to indicate each staff member did not constitute a potential risk for spreading the COVID-19 to residents or other staff before they returned for duty at the facility. Class III	A 078		
A1300	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;	A1300		

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A1300	Continued From page 13 E. Facility residents; F. Attorneys of Record for residents in Adult Mental Health and Treatment Facilities or forensic facilities for court-related matters if virtual or telephonic means are unavailable; G. Public Guardians as set forth in chapter 744, Florida Statutes, Professional Guardians as defined by subsection 744.102(17), and their professional staff pursuant to subsection 744.361(14), Florida Statutes; H. Attorneys and their legal staff who are acting in their capacity as the legal representatives of residents where (a) the residents and lawyers are engaged in an active attorney-client relationships, (b) the visit is related to representation in legal proceedings or in consultation on legal matters, and (c) virtual or telephonic means are unavailable; I. Representatives of the federal or state government seeking entry as part of their official duties, including but not limited to Long-Term Care Ombudsman program, representatives of the Department of Children and Families, the Department of Health, the Department of Elderly Affairs, the Agency for Health Care Administration, the Agency for Persons with [illegible], 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	A1300		

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A1300	Continued From page 14 encouraging with eating or drinking, or emotional distress or decline. ii. Regarding compassionate care visitors, the facility shall: 1. Establish policies and procedures for designation and utilizations of compassionate care visitors; 2. Set a limit on the total number of visitors allowed in the facility based on the ability of staff to safely screen and monitor visitation; 3. Develop an agreeable schedule in concert with the residents and visitors, including evening and weekends, to accommodate work or childcare barriers; 4. Provide instructional signage throughout the facility and prevention and control education, including education on proper use of PPE, hygiene, and social distancing; 5. Designate key staff to support prevention and control training; 6. Screen compassionate care visitors to prevent possible introduction ofCOVID-19; 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;	A1300		

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A1300	Continued From page 15 2. Participate in facility-provided training on prevention and control, use of PPE, use of masks, sanitation, and social distancing, and sign acknowledgement of completion of training and adherence to the facility's prevention and control policies; 3. Comply with facility-provided COVID-19 testing, if offered; 4. Visit in the resident's room or in facility-designated visitation areas within the building; and 5. Maintain social distance of at least six with staff and other residents and limit movement in the facility except compassionate care visitors are not required to maintain social distance from the resident being visited. . The facility may require compassionate care visitors to submit to facility-provided COVID-19 testing so long as use of testing is based on the most recent CDC and U.S. Food and Drug Administration (FDA) guidance. K. General visitors, i.e. individuals other than compassionate care visitors, under the criteria 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	A1300		

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A1300	Continued From page 16 minimum; 5. Adequate cleaning and supplies; and 6. Adequate capacity at referral hospitals for the facility. ii. General visitors must: 1. Wear a mask and perform proper hygiene; 2. Sign an acknowledgement form noting receipt and understanding of the facility's visitation and prevention and control policies. 3. Comply with facility-provided COVID-19 testing, if offered; 4. Visit in a resident's room or other facility-designated area; and 5. Maintain social distance of at least six with staff and residents, and limit movement in the facility. iii. Before allowing general visitors, the facility shall: 1. Set a policy to prohibit visitation if the resident receiving general visitors is 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	A1300		

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a resident--other than in a dedicated wing or unit that accepts COVID-19 cases from the community--tests positive for COVID- 19, or is exhibiting symptoms indicating that he or she is presumptively positive for COVID-19, or a staff person who was in the facility in the prior ten (10) days tests positive for COVID-19;

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

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

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

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

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

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

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A1300	Continued From page 18 recent CDC and FDA guidance. L. Barbers and beauty salons may resume services to residents with the following precautions: i. Services are permissible only if: 1. Other than in a dedicated wing or unit that accepts COVID-19 cases, the facility has had no new facility- onset of resident COVID-19 cases in the previous fourteen (14) days; and 2. Fourteen (14) days have passed with no new staff COVID-19 cases where a positive staff person was in the facility in the ten (10) days prior to the positive test. ii. Barbers and salon staff must wear surgical masks, gloves, practice proper . . . hygiene, and follow the same requirements as compassionate caregivers; iii. Waiting customers must follow social distancing guidelines; . Residents receiving services must wear . . . masks; v. Services are only provided to facility residents, not outside clients or guests; 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	A1300		

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A1300	Continued From page 19 symptoms of, or disclosing the presence of a , including , chills, , repeated shaking with chills, new loss of taste or smell, or any other COVID-19 symptoms identified by the CDC. C. Any person who has been in close contact with any person(s) known to be with COVID-19, who does not meet the most recent criteria from the CDC to end , 3. All facilities must require any individual who is entering the facility and who will have physical contact with any resident to wear PPE pursuant to the most recent CDC guidelines. Persons without physical contact with any resident must wear a mask. All facilities are encouraged to provide regular COVID-19 testing for staff and visitors. 4. Any resident leaving the facility temporarily for medical , , or other activities, and any resident receiving visits from health care 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:	A1300		

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A1300	Continued From page 20 A. Individuals entering a facility must be screened. To achieve this purpose, a facility may use a standardized questionnaire or other form of documentation. B. The facility is required to maintain documentation of all non-resident individuals entering the facility. The documentation must contain: i. Name of the individual entering the facility; ii. Date and time of entry; and iii. The screening mechanism used by the facility to conclude that the individual did not meet any of the enumerated COVID-19 screening criteria. This documentation must include the screening employee's printed name and signature. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow current protocols to screen all visitors upon entry to the facility per the Florida Division of Emergency Management (DEM) Order 20-011 dated as evidenced by inconsistent screening and documentation of visitors entering the facility. This failure has the potential to put the 34 of 34 residents residing in the facility at risk for potential exposure to the COVID-19 . The findings included: Review of ongoing CDC.gov Interim Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus 2019 (COVID-19) Pandemic guidance on revealed the following: Recommended routine prevention and control practices during the COVID-19 pandemic includes establishing a process to ensure everyone (patients, healthcare personnel, and	A1300		

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visitors) entering the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed SARS-CoV-2 and that they are practicing source control. Options could include (but are not limited to) individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, people report absence of and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 in the prior 10 days, and confirm they have not been exposed to others with SARS-CoV-2 during the prior 14 days.

Review of the facility's Control Policies and Procedures COVID 19, documented updated on , states in part, 'The ALF has developed and implemented control practices that conform to Agency for Health Care Administration (AHCA) regulations, CDC guidelines, federal, state and local regulations and currently accepted standards of practice. The ALF staff is assigned responsibility for the management of prevention and control activities.' Further review revealed the facility's Control Policy included AHCA's 'Safe and Limited Re-Opening of Long-Term Care Facilities to include Florida DEM Order 20-011, effective , Questions & Answers (Q&A). Review of this Q&A documented in part under #4 'Visitor Screening and Testing: Does a visitor need to be screened or tested to enter the facility? Answer: Facilities are required to continue visitor screening (i.e. temperature checks and COVID-19 signs, symptoms, and exposure screening questions).'

On at 9:25 AM, 2 surveyors in a regulatory capacity conducted a survey at the facility. Upon entering, the 2 surveyors were

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A1300	Continued From page 22 greeted by the Medication Technician (Med Tech) Supervisor on duty. While waiting in the lobby area, a gentleman, later identified as the facility's hair dresser, was observed pushing Resident #12 out of a room labeled the "Beauty Salon." The hair dresser gathered his personal items, entered the small lobby area, took his temperature with an automated thermometer (a scanning device/screen positioned on a stand that detects a person's body temperature), and left the facility without signing out on the facility's Sign In/Sign Out log that was observed sitting on the table in the lobby. This hair dresser was not observed to inform any staff of his temperature reading or be assessed by any facility staff. At approximately 9:30 AM, the Med Tech Supervisor returned to the lobby area and escorted the survey team through the dining area and into a work area. The Med Tech Supervisor failed to ask any questions related to COVID-19 signs and symptoms, status, or possible exposure. On [redacted] at approximately 9:35 AM, the surveyor asked about the screening of visitors, to which the Med Tech Supervisor stated she should have had the two surveyors sign it. The survey team asked the Med Tech Supervisor to complete whatever she usually does upon entrance of any visitors. The Med Tech Supervisor took the surveyors into the lobby and had the surveyors sign in and took their temperatures. She did not ask the surveyors any screening questions related to the COVID-19 . During an interview on at 9:45 AM, the Med Tech Supervisor was again asked the screening process when someone wishes to enter the facility. She explained, she has any visitor sign in and takes their temperature. When asked if she asks any questions to the visitors, she stated she asks why they are there and who	A1300		

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they need to see. The Med Tech Supervisor explained, that visitation is conducted outside and that deliveries are left outside. When asked if there were any other questions that were asked of any visitors, the Med Tech Supervisor stated, 'No'.

During the facility tour that commenced at 10:57 AM, Resident #13 was observed in his room, explaining he had a visitor today, and the visitor was observed in the room. The visitor was introduced to the surveyor.

During the continued facility tour on from 10:57 AM through 11:31 AM, Resident #12 confirmed she had her hair done in the Beauty Salon at the facility this morning by the hair dresser, additionally confirming she had close personal contact with the hair dresser to get her hair done.

On at 12:45 PM, the Assistant Administrator was asked the process for visitors entering the Assisted Living Facility (ALF). The Assistant Administrator explained that anyone coming into the facility needs to sign in and have their temperature taken, are screened for signs and symptoms, as she pointed to the facility log book on the table in the lobby. Review of the facility's Sign In/Sign Out log with the Assistant Administrator lacked any entry by the hair dresser who was observed at approximately 9:25 AM the morning of . The Assistant Administrator was asked about the visitor for Resident #13, and concurred he had not signed in or had his temperature taken. The Assistant Administrator explained that some of the residents prop open the side doors to go outside, and she believed the visitor for Resident #13 had come in through the propped open door and failed to get screened for

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A1300	Continued From page 24 the COVID-19 . . . Further review of the facility's Sign In/Sign Out log revealed 29 entries from through . . . . . lacking documented temperatures seven times. This facility Sign In/Sign Out log also lacked any screening questions related to signs and symptoms of the COVID-19 . . . The Assistant Administrator confirmed they do not document any screening questions related to the COVID-19 . . . , and questioned the surveyor as to what specifically needs to be asked. The surveyor referred the Assistant Administrator to the CDC website for guidance which continues to be updated on an ongoing basis, in addition to their Control Policy which includes DEM Order 20-011, requiring visitors to facilities to be screened prior to entry to prevent the potential for resident risk and exposure to COVID-19. Class III	A1300		
CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.	CZ830		

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CZ830	Continued From page 25 (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive	CZ830		

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CZ830	Continued From page 26 license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on the review of the Emergency Status System (ESS) data and interview, it was determined the Assisted Living Facility (ALF) failed to submit residential information to the online database daily by 10 AM, as per Executive Order 20-51 effective . . . . . , for 30 of 40 days reviewed (-). The findings included:	CZ830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953519	A. BUILDING: _____ B. WING _____	02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CARE COTTAGE	2277 S.E. LENNARD ROAD PORT SAINT LUCIE, FL 34952

(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
CZ830	Continued From page 27 As per Executive Order 20-51, effective , the Agency for Health Care Administration (AHCA) opened the event "COVID-19 Monitoring" in the Emergency Status System (ESS) for residential census information, available beds, and related information statewide. This Executive Order instructs all residential facilities to report their current resident census and available beds daily by 10 AM ET (Eastern Time) starting Sunday, , , until further notice. Review of the ESS data for this ALF from through revealed the following entry dates and times of submission: at 11:24 AM at 9:04 PM at 12:58 AM at 8:11 AM at 10:13 AM at 7:41 AM at 1:26 PM at 8:12 PM at 12:34 AM at 12:17 AM This data revealed only 10 entries were documented during the 40 day look period. Of those 10 entries submitted to the Agency, five entries were submitted after the 10:00 AM deadline. During an interview on at 3:15 PM, the Administrator confirmed she was the person responsible for submitting the ESS data daily by 10:00 AM. When asked about the submission of the ESS data, the Administrator stated, "It is always logged up. Oh, and I didn't do it today." The Administrator explained that more often than not it takes "hours to get logged into the system."	CZ830		

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
	AL11953519	A. BUILDING: _____ B. WING _____	02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ830	Continued From page 28 When told there were only 10 entries during the past 40 days, the Administrator stated that had to be inaccurate as she received confirmation of submission. The Administrator was asked to locate and provide evidence of her submitted data if more entries were identified, and to email the information to the surveyor. No additional information was forthcoming. Unclassified	CZ830		