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
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(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 AMENDED REPORT An unannounced licensure complaint survey, #2020008396, was conducted from [redacted] through [redacted] at Atria Willow Wood. The facility had a deficiency 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; [redacted], 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- [redacted] or 1(800)962-2873. The telephone numbers must be posted in close	A 030		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 1	A 030		

proximity to a telephone accessible by residents 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.

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
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 2 (g) In addition to the requirements of section 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,	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 5 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 interviews and record reviews the facility failed to ensure the health, safety and well-being of Assisted Living and Independent Living residents residing in the same residential building from the potential to contract or transmit the COVID-19 . . by failing to ensure administrative oversight to assess, implement, evaluate and monitor their preparedness for response to the COVID-19 pandemic. This failure increased the risk to all residents and directly affected Resident #1, Resident #2, Resident #3,	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 6 Resident #4, Resident #5, Resident #6, and Resident #7 who the COVID-19 and resided on the Assisted Living wing, Resident #1 and Resident #2 and 2 residents on the Independent Living wing, Resident #4 and Resident #5.This failure created a potential threat to the health and safety of all residents residing in the residential community. The findings included: 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. The facility is a community of assisted living (AL) in one 4 story tower of the building and independent living (IL) in the other 4 story tower of the building with one shared entrance for both towers. The facility is licensed for 180 assisted living beds. The independent living tower has the capacity to house 125 residents. The main first level is a common area shared by both the AL and IL residents residing in both towers. Located on this first level is a large communal seated dining room as well as a smaller dining room located on the AL side and a bistro located at the front entrance, entertainment areas, recreation rooms, , , areas, physician office space, wellness room, mail room, and beauty salon in addition to outdoor amenities to include a pool, shuffle board, and manicured grounds. The facility was undergoing extensive renovations on the main first level common areas in addition to corridors on residential floors on the AL and IL wings on all 4 floors.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 7 On the census on the AL wing was 98 and the census on the IL wing was 123. 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 . An Agency for Health Care Administration (AHCA) statement released on states 'Pursuant to Governor (of Florida) Executive Order 20-51 and the direction of State Surgeon General (of Florida) regarding 2019 Coronavirus (COVID-19), the Agency directs nursing homes and residential healthcare facilities to immediately review facility protocols including visitor screening to ensure precautions are in place to limit introduction of the . The CDC has provided guidance to facilities to screen patients and visitors for symptoms of acute illness (e.g., , difficulty breathing) before entering your healthcare facility.' Review of the facility Outbreak Preventative Protocol Checklist Level 1: No Confirmed COVID-19 Cases in Local Market/No Outbreak of Any Illness in Community, dated , states under Description - 'Closely monitoring communities for illness and following the recommended guidelines from the Centers for Control and Prevention (CDC) regarding the COVID-19 (coronavirus). Strengthen	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 8 best practices and introduce screening protocols.' Based on review of the checklist indicates the Executive Director was responsible to 'Educate all staff on the need for quick identification of a resident with any symptoms of illness and communicate with their supervisor immediately. Display front desk flyer (arriving week of), in an acrylic holder, asking visitors to refrain from visiting if they have been out of the country in the past 14 days, or if they answer yes to any of the screening questions. Deliver Stand- Up messages on proper sneezing, coughing and handwashing etiquette, as directed.' Review of the facility Overview under High Level Highlights documents 'Do not allow anyone into our communities who meet any of the following criteria: 1. They have been diagnosed with or exposed to anyone diagnosed with COVID-19. 2. They have reason to believe that they, or someone in their household or who they are in close contact with, have been exposed to COVID-19. 3. They or anyone in their household has traveled abroad in the last 14 days.' On , at 9:40 AM, an interview was conducted with the former Resident Service Director (also referred to as a Director of Nursing) and recently promoted Executive Director (ED) as of , , and an inquiry was made who was the Executive director on , to which she stated the ED from a sister facility is the Administrator of record however she was not actively involved with this building and never came on site. She stated the ED position has been vacant since and the Assistant ED has been covering the daily responsibilities onsite for the AL and IL communities. She further stated the Regional Vice President of the South Florida Region is available to assist remotely as needed, however	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 9	A 030		

she is not on site on a daily basis as she is responsible for 4 buildings. Additionally, the ED stated she was out of town starting on [redacted] and returned to the facility on the morning of [redacted] and confirmed during this time period her title was Resident Service Director (also referred to as a Director of Nursing). She stated there are 2 Divisional Directors of Care Management who are Registered Nurses who cover the region however they only offer assistance by phone and do not ever come on site. She stated the Resident Services Supervisor Licensed Practical Nurse was covering for her during her absence.

On [redacted] at 12:30 PM an interview was conducted with the Assistant ED in the presence of the current ED who stated a National Operations [redacted] (NOS) from out of state was providing support to the Assistant ED as the ED position remained vacant up until [redacted]. She stated the NOS was on site Monday through Friday and left Friday afternoons to return to her home base out of state. She stated the NOS's last day on site was [redacted] and the facility was now her responsibility with support from the Regional VP who was available by phone. She further stated her primary focus was the residents residing in the IL wing of the facility. An inquiry was made to the Assistant ED how they began to implement their Level 1 COVID-19 outbreak preventative protocol and introduce screening to persons entering the community. She stated they had a laminated 8 by 11 flyer with the screening questions posted at the front desk. An inquiry was made how they communicated this protocol to their staff to which she stated they have Stand-Up meetings Monday through Friday with department directors on the day and evening shifts and leave -outs for the night shift staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 10	A 030		

as there are no department heads working on the night shift. Review of the . Daily Stand Up communication form completed by the Assistant ED documents 'We're in the middle of . season, and coronavirus is in the headlines. washing is the single most effective way to prevent the spread of germs.' Further review of the Stand- Up communication forms provided by the Assistant ED from . . through . . ., , does not indicate any discussion or communication about monitoring residents in the community or following recommended CDC guidelines for screening persons entering the community. A request was made for additional documentation of the Stand-Up communication forms to which she stated she had no record of additional meetings after . An inquiry was made to the Assistant ED how they were following their screening recommendations for persons entering the building to which she stated the front receptionist would ask all persons entering the screening questions however they were not documenting the answers to the questions at that time. The Assistant ED confirmed the screening did not include facility staff. She further stated the construction workers entered the facility through a . . -service entrance. She stated the construction workers were given their daily assignment by the onsite construction manager and the workers had access throughout the building. She stated to her knowledge they were not screened as the construction workers were not under her management responsibilities.

The Assistant ED could not provide any documentation of communication between the construction contractor and the facility to show that the subcontractors were being screened prior to entrance into the facility.
Review of a letter provided via email from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 11 current ED on [redacted] at 12:02 PM, revealed a letter dated [redacted] from the facility Construction Project Manager to the [redacted] of the construction company. In brief the [redacted] letter requests that the contractors comply with meeting the COVID-19 screening criteria that the facility documented they were going to implement on [redacted]. The letter does not indicate or provide instruction in communicating if any of the subcontractors that had visited the building met any of the screening criteria. In the letter no contact person was identified representing the facility with no instruction to contact the management of the facility if there were any concerns with meeting the screening criteria. The onus was on the construction company to ensure compliance with no oversight by the administration of the facility. During the interview with the Assistant Executive Director in the presence of the current Executive Director on [redacted] at 12:30 PM, the current Executive Director confirmed the National Operations [redacted] who was acting Executive Director left the building to return to her home state on [redacted]; the Executive Director of record on paper was responsible for her own building and was not actively involved with this facility; the Regional Vice President was not in the building on a daily basis; the 2 Divisional Director of Care Management Registered Nurses were never on site; the Resident Services Director (also referred to as Director of Nursing) was out of the facility from [redacted] through [redacted]; the Resident Services Supervisor Licensed Practical Nurse was covering in her absence and she along with the Assistant Executive Director were responsible for oversight and coordination to address the increasing guidance as a result of the COVID-19 outbreak and to implement and	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 12 monitor the increasing amount of recommended guidance from the federal, state and local authorities to comply with the facility protocols. The Executive Director further stated she was notified by the county Health Department on the evening of , that Resident #2 tested positive for COVID-19. Review of the Guest Sign-In and Resident Sign-In logs revealed no documentation of responses to the facility screening protocol from through , that was to be implemented on . Review of the facility Outbreak Preventative Protocol Checklist Level 2: No Outbreak of Any Illness in Building/Confirmed Case of COVID-19 in Local Market, dated , states under Description - 'In light of the continued spread of COVID-19 we are stepping up our preventative measures company wide. Reduce resident contact with visitors and guests.' Based on review of the checklist indicates the Executive Director was responsible to 'Remind all visitors to access the building through the main entrance. Lock all other non-staffed entrances. We strongly recommend that family members not take residents out of the building to visit public gathering spaces, including retail stores, theaters, casinos etc. Visits to private family homes are ok.' In the interview conducted on , at 12:30 PM, with the Assistant ED she confirmed the Regional Vice President was only on site at the facility on and and did not return until when the Resident Service Director (also referred to as Director of Nursing) received the call from the county Health Department notifying them there was a resident with a confirmed positive case who had resided in the AL wing of the building.	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 13 Review of the Resident Sign-In logs dated through revealed 12 residents did not heed the facility recommendations to restrict their excursions to public venues by leaving the facility. The 12 residents that left the facility between through were a combination of AL and IL residents going out to the grocery store, shopping to a mall, out for breakfast, to a tire store and to a hair salon. On at 11:10 AM, an interview was conducted with the facility Project Manager who stated the renovation construction in the facility commenced in . He stated they are updating all the common spaces on the main first level in addition to updating the hallways in both the AL and IL wings. He verified that residents from the AL and IL all have access to the common dining and recreation spaces on the first level. An inquiry was made how the construction workers entered the premises to which he stated some may have come through the front entry however the majority would probably have entered through the entrance and checked in with the construction office to get their daily work location. Review of the facility Outbreak Preventative Protocol Checklist Level 3: No Outbreak of Any Illness in Building/Confirmed Case of COVID-19 in Local Market, dated states under Description 'As the situation escalates, we are taking greater measures to ensure the safety and well -being of our residents and staff. Reduce access to community to only employees, residents and essential visitors who meet our stepped-up screening questions.' Based on the review of the checklist indicates the Executive Director was responsible to 'Restrict access to the community to allow essential visits only. Examples of essential visitors include: Vendors	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 14 that provide operationally critical services (pharmacy, mail, food, supplies, construction, maintenance, healthcare providers including hospice and . Display updated screening sign at front entrance that includes 4 screening statements. (The fourth question added to the questions initiated as of , to read 'You currently have any of the following symptoms: , and /or .') Any essential visitors must enter the building through the main, staffed entrance. Lock all other non-staffed entrances. Maintenance and/or construction vendors should continue entering through service or construction entrance.' On at 1:00 PM, an interview was conducted with the facility Project Manager and an inquiry made when the facility renovations project were suspended to which he stated the directive to cease renovations was made on and the last construction workers would have been in the building up until the end of their afternoon shift on Friday . A further inquiry was made if a construction worker assigned to do interior renovations would not be considered operationally critical services under the Level 3 Protocol, to which he stated construction workers are not essential workers. Review of the Resident Sign- In Log dated , revealed 6 residents did not heed the facility recommendations to restrict excursions to public venues by leaving the facility. The residents that left the facility on were a combination of AL and IL residents going out with family, going to the store or going for a ride. Review of the facility Symptom Tracking Log, date initiated documents	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 15 Resident #1 who resided on the AL wing of the facility, was sent to the hospital on due to and . He was diagnosed with , . He tested positive for COVID-19 on . Resident #1 expired in the hospital on . Resident #1 never returned to the facility. Resident #2 who resided on the AL wing of the facility was sent to the hospital on due to . He was tested positive for COVID-19 on . Resident #2 expired in the hospital on , Resident #3 who resided on the AL wing of the facility, started to experience symptoms of and on . On , her temperature remained elevated and she was sent to the hospital for evaluation. Resident #3 tested positive for COVID-19 on , . Resident #3 returned to the facility on . Resident #4 who resided on the IL wing of the facility was sent out to the hospital on , after sustaining a . In the hospital she was diagnosed with , . Resident #4 tested positive for COVID-19 on . Resident #4 expired in the hospital on , Resident #5 who resided on the IL wing of the facility was sent out to the hospital on , after sustaining a and experiencing . Resident #5 tested positive for COVID-19 in the hospital. Resident #5 expired on . Resident #6 who resided on the AL wing of the facility, was sent to the hospital on , with a . Resident #6 tested positive for COVID-19 on . Resident #6 returned to the facility on , Resident #7 who resided in the AL wing of the	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 16 facility was sent to the hospital on . . . . . with a and . Resident #7 tested positive for COVID-19 on . . . . . Resident #7 returned to the facility on , ... Further review of the . . . . Symptom Tracking form revealed on , , 2 residents residing on the IL wing of the facility were sent out to the hospital and tested positive for COVID-19. On . . . . . , 3 residents residing on the IL wing of the facility were sent out to the hospital and tested positive for COVID-19. Review of the Governor of Florida's Emergency Order 20-52 in response to COVID-19 public health emergency which poses a severe threat to the entire state of Florida states in part as of , prohibits individuals from visiting facilities within the State of Florida. For purpose of this order a facility includes Assisted Living as provided under Chapter 429. Individuals seeking entry will not be allowed to enter if they meet any of the screening criteria listed below: A. Any person with COVID -19 who has not had 2 consecutive negative test results separated by 24 hours. B. Any person presenting signs or symptoms of or disclosing the presence of a , , , including , , ... or . . . . . C. Any person who has been in contact with any person or persons known to be . . . . . with COVID-19 who has not yet tested negative for COVID-19 within the past 14 days. D. Any person who travelled through any airport within the past 14 days or any person who travelled on a cruise ship within the past 14 days. 4. Residents must be discouraged from leaving the facility. 5. The following documentation must be kept for visitation within a facility. A. Individuals entering a facility subject to the screening criteria above, may be screened	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 17 using a standardized questionnaire or other form of documentation. B. The facility is required to maintain documentation of all non- resident individuals entering the facility. Documentation must include 1) name of the individual 2) date and time of entry and 3) the documentation used by the facility to screen the individual showing the individual did not meet any of the enumerated screening criteria, including the screening employees name and signature. Review of the facility Outbreak Preventative Protocol Checklist Level 4: No Outbreak of Any Illness in Building/Confirmed Case of COVID-19 in Local Market, dated . . . . . states under Description-'As states issue varying guidance, we are working to align, and create one protocol applicable across the entire portfolio. Further access restrictions and screening measures. All essential visitors must: Have their temperature taken by the front desk employee or designee. Answer No to all four community screening questions. Have their temperatures recorded on the visitor sign-in sheet next to their name. Based on the review of the checklist indicates the Executive Director was responsible to 'Restrict access to the community to allow essential visits only. Upon arrival at the buildings, essential visitors, employees, aides and companions must check in at the front desk and have their temperature taken by the front desk employee or designee. Temperatures should be recorded in the Resident Sign- In Sheet and Communications Log. Any essential visitors must enter the building through the main, staff entrance. Lock all other non-staffed entrances. Preventative maintenance and essential repair vendors should continue entering through service entrance. Other than outside medical . . , we strongly recommend that family	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 18 members not take residents out of the building under any circumstances including visits to private family homes or public gathering spaces (grocery stores, theaters, religious services, casinos etc. Residents may be subject to a 14-day , following the outing.' Review of the Guest Sign-In sheets dated , , 48 private duty aides and companions and 10 family members entered the facility. Review of the Resident Sign-In Log dated , revealed 3 residents did not heed the facility recommendations to restrict excursions to public venues by leaving the facility. Further review of the Guest Sign- In Log and Resident Sign-In Logs dated , revealed no documentation temperatures were obtained of any of the visitors or residents who entered the facility and no evidence of the 4 screening questions that were required to be asked were not documented on the Logs. Review of the Guest Sign-In sheets dated , , revealed 21 private duty aides and companions and 4 family members entered the facility, one private duty aide and 2 family members did not have a temperature check logged. Review of the Resident Sign-In Log dated revealed 7 residents did not heed the facility recommendations to restrict excursions to public venues by leaving the facility. Further review of the Resident Sign-In Log dated , , revealed 4 of the 7 residents who left and returned to the facility had no temperature checks logged. On , , at 12:00 PM an interview was conducted with the Resident Services Supervisor Licensed Practical Nurse, who stated on , she called the paramedics for Resident	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(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	Continued From page 19 #3 due to the resident showing symptoms of a . She stated when the paramedics arrived, they requested she take the resident's temperature however she was unable to do so as there were no thermometers in the building. The paramedics did not transport the resident to the hospital at this time. She further stated on , she called the paramedics again for Resident #3 who was transported to the hospital with signs and symptoms of a and diagnosed at the hospital with , and admitted to the . Review of the facility protocol for Level 4 Outbreak Preventative Protocol Checklist dated , clearly documents the Executive Director is responsible for implementing the following: Upon arrival at the building, essential visitors, employees, aides and companions must check in at the front desk and have their temperature taken by the front desk employee or designee Temperatures should be recorded in the Resident Sign In Sheet and Communication Log.' The facility failed to follow this directive as there was no thermometer in the building. On , at 12:30 PM an interview was conducted with the Assistant ED who stated she worked the weekend of and due to the new facility protocols being implemented. She stated she received an email on from the local fire marshal stating they need to take temperatures. She stated she purchased 3 thermometers in response to the potential increasing monitoring requirements and the Engage Life Director went out to the pharmacy and purchased a thermometer on . She was apprised the Resident Service Director Licensed Practical Nurse had stated during the interview at at	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 20 12:00 PM, she was unable to take Resident #3's temperature due to no thermometers in the building. The Assistant ED did not respond. An inquiry was made how they implemented their screening protocols at the front desk for the requirement to document temperatures and ask the 4 screening questions of all essential visitors the entering facility. She stated they were asking the screening questions but had not documented such and did not start documenting the screening questions until . . . . The Assistant ED confirmed they were not following the requirements as set out in the Governor of Florida's Emergency Order dated , ... On . . . , at 1:35 PM, an additional interview was conducted with the Assistant ED and a request made to provide the date the thermometers were purchased. She stated she will refer to the purchase statements. At 1:40 PM the Assistant ED provided a handwritten accounting of the purchase of the thermometers. 3 thermometers were purchased on . and one was purchased on . . . . . The Assistant ED stated the 3 thermometers were delivered on the 16th and the Engage Life Director went in person to the pharmacy on the 15th and purchased a thermometer. The Assistant ED confirmed there were no thermometers in the building until . . . . . She further stated they started taking visitor and residents temperatures who entered the facility on . On . . . , ... at 1:40 PM, an interview was conducted with the Executive Director, former Resident Services Director (also referred to as Director of Nursing), who was present during the interview with the Assistant ED. An inquiry was made if a resident displayed symptoms of	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 21 how would they evaluate the resident if they had no thermometers on site. The Executive Director stated they do not take resident temperatures or vital signs in addition they do not check the resident for a . An inquiry was made if a resident expressed they had a and requested , what would they do, to which she stated they do not accept orders for , for a as they do not check temperatures. Further, information obtained during the onsite review on , included the Guest Sign-In sheets dated , revealing 56 private duty aides and companions entered the facility and had their temperatures taken however only 29 screening questionnaires were completed. Review of the Guest Sign-In sheets dated , revealed 42 private duty aides and companions entered the facility and had their temperatures taken however only 12 screening questionnaires were completed. No evidence of documentation was provided to verify the staff were being screened as per the protocol under Level 4 to have their temperatures taken and screening questions asked for . On at 2:30 PM, an onsite facility control visit was conducted due to notification by the Florida Department of Health, a resident from the facility had tested positive for the COVID-19 . The control team consisted of a Registered Nurse from the Agency for Health Care Administration and an Environmental Manager representative from the Florida Department of Health. Entrance to the facility was made through a locked and alarmed	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 22 . . . door. Upon meeting with the Resident Service Director (also referred to as the Director of Nursing (DON) and Regional Vice President they both were not wearing masks despite being aware one of their residents had tested positive for the COVID-19 . Facility staff were observed in the hallways and closed dining room and common areas and not one staff member was observed wearing a mask. In the administrative office, an interview was conducted at 2:35 PM with the Resident Service Director (DON) and Regional Vice President. The Resident Service Director (DON) stated she had been out of the facility and returned on , ... She stated she received a call late in the evening of from the Department of Health informing them Resident #2, who remained in the hospital, had tested positive for the . . . The Resident Service Director (DON) stated at that point, she called in all the department directors to come to the facility to coordinate a plan. She further stated she has been on site for 36 hours. The Regional Vice President stated she arrived to the facility late evening on . . . . , ... when she received the call from the Resident Service Director (DON). The Regional Vice President stated a Department of Health team was in the building late in the evening of . . . . , ... up until about 6:00 AM on , and they visited every resident residing in the AL and IL towers. An inquiry was made to the Resident Service Director (DON) about the status of Resident #2 to which she stated Resident #2 resided in the AL tower and on . . . . . began to have some so they sent him out to the hospital. She stated he lived on the AL side but was very social with both residents on the AL and IL towers. The Resident Service Director (DON) confirmed all residents living on	A 030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 23 the AL and IL towers shared all the first floor dining room and amenities. On [redacted] at 4:00 PM, during a tour of the first floor AL wing, accompanied by the DOH representative and Regional Vice President, an interview was conducted with a Medication Technician at her medication cart on a first-floor hallway of the AL tower. An inquiry was made how are they are screening or monitoring their residents to which she stated she asks the residents how they are feeling. An inquiry was made to the Medication Technician if she is monitoring resident temperatures to which she stated she does random temperature checks but does not check all resident temperatures. The Regional Vice President was advised by the Registered Nurse AHCA representative in order to fully assess their residents for signs and symptoms of illness, all resident temperatures should be checked at least daily or more often if possible. The Regional Vice President acknowledged this and stated they have obtained additional thermometers that they can utilize. Review of the facility protocol for Level 5: No Outbreak of any Illness in Building/Confirmed Case of COVID-19 in Local Market dated [redacted] documents the Executive Director was responsible for implementing the following: All employees, aides and companions will wear a surgical [redacted] mask while within six [redacted] of residents. [redacted] masks should be changed when soiled or wet, and when they go on break. Review of an AHCA statement released [redacted] states, 'Effective immediately staff of residential and long-term care facilities are to implement universal use of [redacted] masks while in the facility. It is important to keep [redacted] away from the mask and only touch the straps of the	A 030		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911596	A. BUILDING: _____ B. WING _____	05/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIA WILLOW WOOD	2855 WEST COMMERCIAL BLVD FORT LAUDERDALE, FL 33309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 030	Continued From page 24 mask. Gloves are to be worn when providing care to the resident.' Class III	A 030		