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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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<br><br>A Complaint investigation #2021003686 was conducted at Silver Creek Assisted Living St. Cloud on . Deficiencies were identified at the time of the visit. | A 000 | | |
| A 008 SS=D | 429.26( ) FS; 59A-36.006(2) FAC Admissions - Health Assessment<br><br>429.26<br>(5) Each resident must have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner ' s form or on a form adopted by agency rule. The medical examination form, signed only by the practitioner, must be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form may only be used to record the practitioner ' s direct observation of the patient at the time of examination and must include the patient ' s medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident ' s admission to or continued residency in the facility. The medical examination form, reflecting the resident ' s condition on the date the examination is performed, becomes a permanent part of the facility ' s record of the resident and must be made available to the agency during inspection or | A 008 | | |

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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 008 | Continued From page 1<br><br>upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.<br>(6) Any resident accepted in a facility and placed by the Department of Children and Families must have been examined by medical personnel within 30 days before placement in the facility. The examination must include an assessment of the appropriateness of placement in a facility. The findings of this examination must be recorded on the examination form provided by the agency. The completed form must accompany the resident and be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or , , nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that it was completed within 90 days prior to admission to the facility. The Department of Children and Families shall provide to the facility administrator any information about the resident which would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special | A 008 | | |

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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 008 | Continued From page 2<br>needs of the resident and advise the operator whom to call should problems arise. The Department of Children and Families shall advise and assist the facility administrator when the special needs of residents who are recipients of , , , require such assistance.<br><br>59A-36.006<br>(2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a -to- medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection.<br>(a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following:<br>1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations,<br>2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living,<br>3. Any nursing or services required by the individual,<br>4. Any special diet required by the individual,<br>5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication,<br>6. Whether the individual has signs or symptoms of , , or any other communicable , which are likely to be transmitted to other residents or staff,<br>7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, | A 008 | | |

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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 008 | Continued From page 3<br><br>8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S.<br>(b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed.<br>1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider.<br>2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided.<br>3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823.<br>(c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. | A 008 | | |

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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 008 | Continued From page 4<br><br>(d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b).<br>(e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule.<br>(f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida . . . . . Form, for residents who do not wish . . . . . to be administered in the case of or .<br>(g) A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission.<br><br>This Statute or Rule is not met as evidenced by: | A 008 | | |

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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 008 | Continued From page 5<br><br>Based on resident record review and interview, the facility failed to ensure the health assessment (AHCA form 1823) was complete and accurate for 2 of 4 residents sampled. (#2 and #3)<br><br>Findings:<br><br>1. Review of the record for resident #2 revealed an admission date of . . . . . The most recent health assessment was dated and was found to be incomplete. There were 3 pages of page 4 (of 5) of the form. Page 4 listed the resident's medications and included a section for the provider to sign. On one of the page 4 sheets "medication administration" was checked. On the other 2 sheets, the page 4 sections were left blank for the type of assistance needed for medications. In addition, none of the physician signature blocks on any of the pages was complete with the physician's address and phone number. Page 5 of the form was not found. (photographic evidence obtained)<br><br>On at 12:20PM, the facility manager confirmed the facility does not have nurses and cannot provide medication administration. She stated she had not noticed the form was incomplete and inaccurate.<br><br>2. Review of the record for resident #3 revealed an admission date of . . . . . The health assessment in the record was not signed or dated by the provider. The form documented the resident did not require assistance with medications.<br>(photographic evidence obtained)<br><br>On at 12:20PM, the facility manager confirmed the findings. | A 008 | | |

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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 008 | Continued From page 6<br>Class III | A 008 | | |
| A 025 SS=D | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making , , for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.<br><br>59A-36.007<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C.<br>(b) Daily observation by designated staff of the activities of the resident while on the premises, | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 025 | Continued From page 7<br><br>and awareness of the general health, safety, and physical and emotional well-being of the resident.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on resident record review, facility observation notes, and incident reports, the facility failed to maintain documentation of significant changes or illnesses that resulted in medical attention, or documentation of notification to the resident's provider or responsible party following significant changes for 2 of 4 sampled residents. (#2 and 34)<br><br>Findings:<br><br>1. Review of the record for resident #2 revealed an admission date of . . . . . . . . . The admission health assessment (AHCA form 1823) was dated . . . . . . . . . Another 1823 dated . . . . . was revealed following the most recent hospital admission. Facility "observation notes" reviewed from , - revealed a short | A 025 | | |

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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 025 | Continued From page 8<br><br>weekly note regarding showers, bed linens changed. Continued review did not find any notes or documentation regarding when or why the resident went to the hospital, or if the resident's provider or responsible party was notified. (photographic evidence obtained)<br><br>On at 12:30PM, the facility manager stated resident #2 had been in and out of the hospital several times and confirmed she did not have any notes documenting any of the incidents leading to the hospital visits, when she returned, or who was notified of those incidents.<br><br>2. Review of the closed record for resident #4 revealed an admission date of . The most recent health assessment was dated and documented diagnoses which included ( ), . She required assistance with most activities of daily living but needed supervision for eating and grooming. She was receiving hospice services since . Hospital notes were found for a admission for exacerbation. A hospital note for a emergency room visit after a was found. There was a facility incident report regarding the which indicated the and the resident was sent to the hospital with a to the right . The form did not indicate if the resident's hospice provider was notified. "Resident Family/Representative" was circled but there were no notes as to who was notified or when. Review of the medication observation record (MOR) for revealed an "I" noted for medications beginning with the evening doses on . The reverse side of the MOR did not indicate what the "I" represented. Continued review did not reveal any | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 025 | Continued From page 9<br><br>documentation explaining the events leading up to the hospital admissions or emergency room visits, returns from the hospital or emergency room, if any providers, hospice or family were notified, or if any changes had been ordered to the care the resident required as a result of the significant events.<br>(photographic evidence obtained)<br><br>On at 12:30PM, the facility manager stated resident #3 went to the hospital on because she had . She stated the hospice nurse had visited in the morning in response to the . She said the resident's son insisted she be sent to the hospital even though she was receiving hospice care, so they sent her to the hospital that afternoon. She said she was informed the resident , in the hospital. She confirmed there were no facility notes documenting the in or any changes leading to the hospital admission on .<br><br>On at 12:20PM, staff A, caregiver, stated they fill out incident reports when needed and write in the shower logbook. She said they do not write any other notes about the residents in their records.<br><br>On at 12:30PM, staff B, caregiver, stated they verbally report to each other when shifts changes, but she was told they were not allowed to write notes about the residents' conditions or changes. She said they do have incident reports they would complete if something happened, and they have weekly shower logs they made notes on.<br><br>On at 12:45PM, the facility manager stated the staff verbally reported to each other and text messaged the resident's families. She | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 025 | Continued From page 10<br>confirmed they did not have any documentation about changes in a resident's condition or behavior. She confirmed communication with the resident's families and providers was not documented in the resident records.<br><br>Class III | A 025 | | |
| A 056 SS=D | 59A-36.008(7) FAC Medication - Labeling and Orders<br><br>(7) MEDICATION LABELING AND ORDERS.<br>(a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:<br>1. The resident's name; and,<br>2. The identification of each medicinal drug in the container.<br>(b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another.<br>(c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, | A 056 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 056 | Continued From page 11<br>including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.<br>(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record.<br>(e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable.<br>(f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner.<br>(g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the | A 056 | | |

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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 056 | Continued From page 12<br><br>manufacturer's labeled package, they must be kept in a container that bears a label containing the following:<br>1. Practitioner's name,<br>2. Resident's name,<br>3. Date dispensed,<br>4. Name and strength of the drug,<br>5. Directions for use; and,<br>6. Expiration date.<br>(h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record reviews and interview, the facility failed to make every reasonable effort to ensure prescriptions were filled in a timely manner for 1 of 4 sampled residents (#4).<br><br>Findings:<br><br>Review of the closed record for resident #4 revealed an admission date of . The most recent health assessment was dated and documented diagnoses which included ( ), . She required assistance with most activities of daily living but needed supervision for eating and grooming. She was receiving hospice services since . Review of the medication observation record (MOR) for revealed , , (a , reliver) 10mg, 1 tablet three times daily for , , was documented as not given on at 2pm and 10pm, not given for any doses on or the 6am and 2pm doses on . | A 056 | | |

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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 056 | Continued From page 13<br><br>The reverse side of the MOR noted / 6am "do(n't) have any more" and on the 2pm and 10pm doses for and all doses for noted "waiting on script." There were no notes regarding who was contacted or when. Continued review of the MOR revealed " 4% patch, apply 1 patch to painful area daily on for 12 hours, apply at 8pm, take off at 8am." The 4% patch was marked as not given on all days in . The reverse side of the MOR documented "don't have any more" or "Don't have" for most dates in . There were no other notes found to show if the provider or pharmacy was contacted regarding this medication, or when. Also revealed was an "I" noted for medications beginning with the evening doses on . The reverse side of the MOR did not indicate what the "I" represented.<br><br>On at 12:45PM, the facility manager stated they call the doctor and pharmacy when medication refills are needed. She confirmed they did not have any documentation regarding the medications and who was contacted.<br><br>Class III | A 056 | | |
| A 162 SS=D | 59A-36.015(3) FAC Records - Resident<br><br>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:<br>(a) Resident demographic data as follows:<br>1. Name,<br>2. ,<br>3. Race,<br>4. Date of birth,<br>5. Place of birth, if known,<br>6. Social security number, | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 162 | Continued From page 14<br>7. Medicaid and/or Medicare number, or name of other health insurance ,<br>8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and,<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.<br>(c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.<br>(f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually.<br>(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.<br>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 162 | Continued From page 15<br>(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.<br>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.<br>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S.<br>(l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.<br>(m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.<br>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.<br>(o) The resident's , DH Form 1896, if applicable.<br>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 162 | Continued From page 16<br><br>who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility:<br>1. A log listing the names of residents participating in this arrangement,<br>2. The resident demographic data required in this paragraph,<br>3. The health assessment described in rule 59A-36.006, F.A.C.,<br>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,<br>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.<br>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.<br>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on resident record review and interview, the facility failed to maintain documented [illegible] for 3 of 4 sampled residents at least semi-annually (#2, 3, 4).<br><br>Findings: | A 162 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 162 | Continued From page 17<br><br>1. Review of the records for residents #2, #3 and #4 revealed they required assistance with activities of daily living.<br><br>Review of the record for resident #2 revealed an admission date of . The most recent health assessment was dated and included a . Review of the facility record revealed it contained only one , dated of .<br><br>2. Review of the record for resident #3 revealed an admission date of . Review of the record revealed the most recent was recorded on .<br><br>3. Review of the closed record for resident #4 revealed an admission date of , and a discharge date of . Review of the record for resident #4 found only one documented on , the day she was sent to the hospital.<br>(photographic evidence obtained)<br><br>On at 12:45PM, the facility manager confirmed the findings.<br><br>Class III | A 162 | | |
| CZ830 | 408.821 FS Emergency Management Planning<br><br>408.821 Emergency management planning; emergency operations; inactive license.-<br>(1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency | CZ830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 18<br><br>management plan to the local emergency management agency, county health department, or Department of Health as follows:<br>(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.<br>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.<br>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.<br>(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.<br>(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.<br>(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:<br>1. Suffered damage to its operation during the state of emergency.<br>2. Is currently licensed.<br>3. Does not have a provisional license.<br>4. Will be temporarily unable to provide services | CZ830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 19<br><br>but is reasonably expected to resume services within 12 months.<br>(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on daily Emergency Status System (ESS) report review and interview the facility failed to | 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 |
|---|---|---|---|
| | AL11967456 | A. BUILDING: _____ B. WING _____ | 03/23/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SILVER CREEK ASSISTED LIVING ST CLOUD | 2910 OLD CANOE CREEK ROAD SAINT CLOUD, FL 34772 |

| (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 20<br><br>report the facility's daily census and covid-19 status of residents and staff.<br><br>Findings:<br><br>Review of the ESS report for revealed that the facility last reported their census status and covid-19 and status on .<br><br>On at 9:50AM, the facility manager confirmed the finding and said the administrator usually did it, but there was a problem with the log-on.<br><br>Unclassified | CZ830 | | |