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
	AL11969737	A. BUILDING: _____ B. WING _____	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF CAPE CORAL THE	2219 CHIQUITA BLVD S CAPE CORAL, FL 33991

(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 An unannounced complaint survey for #2021010826 was conducted on .. .. .. at The Waters of Cape Coral, an assisted living facility in Cape Coral, Florida. Complaint #2021010826 was substantiated at A0011. The following is description of the deficiencies.	A 000		
A 011	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure that residents transferred to the hospital were allowed to return when determined to be inappropriate for hospitalization for 6 (Residents #1, #2, #3, #4, #5, and #6) of 6 residents sent out to the hospital. Furthermore, the facility failed to notify the Department of Health (DOH) when the first person returned a positive Covid-19 test. Failure to notify DOH of positive Covid activity in the facility contributed to the lack of direction on transfers to the hospital. The findings included: 1. Interview on .. .. .. from 1:00 p.m. to 4:30 p.m., with the Administrator and Wellness Director revealed they had 6 staff out with positive Covid-19 tests or reported exposures:	A 011		

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A 011	Continued From page 1 Food service Staff A called in sick on . She was tested on and returned with a positive Covid test. Patient care Staff B reported exposure from family on 7/2821. Administrative Staff C reported not feeling well on , but returned to work on to . She tested positive for Covid on . Staff C was fully . Patient care Staff D worked on and during the shift reported not feeling well. Staff D was tested and was positive for Covid. Staff D was fully . Patient care Staff E worked on , then called called in not feeling well on . Testing was completed on , and Staff E tested positive. Staff E was fully . Patient care Staff F worked on . On during Covid testing Staff F tested positive. Staff F was , , , but had not been . Interview on from 1:00 p.m. to 4:30 p.m., with the Administrator and Wellness Director revealed they had not notified the DOH from until . 2. Interview on from 1:00 p.m. to 4:30 p.m., with the Administrator and Wellness Director revealed they had 7 residents out with positive Covid-19 tests: Resident #1 displayed symptoms of Covid on . He was tested and found to be positive.	A 011		

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A 011	Continued From page 2 He was sent to the hospital, and refused re-admission. Resident #1 was fully . Resident #2 displayed symptoms of Covid on . He was tested and found to be positive. He was sent to the hospital, and refused re-admission after an Emergency Room physician determined hospitalization was not warranted. Resident #2 was fully . Resident #3 displayed symptoms of Covid on . He was tested and found to be positive. He was sent to the hospital, and refused re-admission after an Emergency Room physician determined hospitalization was not warranted. Resident #3 was fully . Resident #4 displayed symptoms of Covid on . She was tested and found to be positive. She was sent to the hospital, and refused re-admission after an Emergency Room physician determined hospitalization was not warranted. Resident #4 was fully . Resident #5 displayed symptoms of Covid on . She was tested and found to be positive. She was sent to the hospital, and refused re-admission after an Emergency Room physician determined hospitalization was not warranted. Resident #5 was not fully . Resident #6 displayed symptoms of Covid on . He was tested and found to be positive. He was sent to the hospital, and refused re-admission after an Emergency Room physician determined hospitalization was not warranted. Resident #6 was not fully . Resident #7, the spouse of Resident #2, displayed symptoms of Covid on . She was	A 011		

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A 011	Continued From page 3 tested and found to be positive. Resident #7 was fully . Interview on from 1:00 p.m. to 4:30 p.m., with the Administrator and Wellness Director revealed the Wellness Director believed when they sent the residents to the hospital, that the hospital would have to keep them until they had 2 negative tests. The Wellness Director referred to the Hospital to Post Acute Care Facility Transfer Covid-19 Positive form developed by the Associations and up-dated . The form showed, "This patient has tested Covid-19 positive and continues to require transmission-based isolation per CDC guidelines. , be transferred to a Covid-19 + facility. The Administration did not consider themselves to be a Covid-19 positive facility as due to staff shortages from Covid-19, they could not provide "dedicated" staff to care for the residents. On , the DOH staff present provided guidance on staff utilization and PPE usage to ensure further protection to residents being care for both Covid positive and Covid negative. On , the room roster was reviewed and rooms set aside as a potential Covid-19 unit were identified. A tour of the facility with DOH staff, the Administrator and Wellness Director revealed due to most rooms being private rooms, recuperation would be possible in private rooms, and the facility only would have to separate roommates who were positive and negative. Class III	A 011		