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
	AL11964922	A. BUILDING: _____ B. WING _____	11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFICA SENIOR LIVING OF PALM BEACH	4760 JOG ROAD GREENACRES, FL 33467

(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 Relicensure with Extended Congregate Care (ECC), Complaint (#2021001319, #2021002665, #2021002919, #2021014013, #2021016161 and #2021016175) and Generator Monitoring Survey was conducted on through at Pacifica Senior Living of Palm Beach. The facility had deficiencies identified related to the Relicensure and Complaint (#2021014013) at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of 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. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents	A 025		

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A 025	Continued From page 1 accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to provide the supervision necessary to ensure the safety and well being of 1 of 4 sampled residents reviewed, specifically Resident 17. The findings included: Review of the facility's Clinical Policy & Procedure	A 025		

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A 025	Continued From page 2 Manual - Florida, provided during the survey revealed at GP 26-Staffing, First Aid and [illegible] ( ) dated [illegible] documents that the Executive Director is responsible to ensure properly trained staff members are available to respond to emergencies and ensure the necessary care and supervision to residents. It further states that each community is to provide for a sufficient number of staff to a) Provide care required in each resident's written record of care. b) Ensure the health, safety, comfort, and supervision of the resident. Review of Resident #17's Health Assessment AHCA form 1823 dated [illegible] documents her diagnosis as: [illegible], Risk of [illegible] and [illegible]. A review of Resident #17's facility file also revealed an End of Shift Report dated [illegible] documenting: "Came in at 11:00 to release 3 to 11 shift. (Certified Nursing Assistant (CNA)Staff H) mentioned to me that (Resident #17) was still outside, didn't have dinner and refused to be changed checked on her still seated outside but refused to come inside so when Caregiver Staff C came in at 11:45 I mentioned to her about (Resident #17) being outside to keep an [illegible] on her she used to bring her inside but talked and get scratched. In the morning when I came [illegible] (Caregiver Staff C) told me that (Resident #17) didn't come inside she stayed outside before I left that when me and the incoming shift found her on the ground called paramedics while giving [illegible] till they arrived at the scene." A review of an investigative report from a State Agency documented in part at 5:19 AM the CNA checked on her this morning at around 7:00 AM	A 025		

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A 025	Continued From page 3	A 025		

there was a shift change at around 7:14 AM, when the staff went outside to check on (Resident #17) she was found on the ground . . . . . The staff member let her stay outside all night. She was found by staff at 6:30 AM . . . down soaking wet .

In an interview conducted with Caregiver Staff C on . . . . . at 9:41 AM, she stated she works the 11:00 PM to 7:00 AM shift and was working in the cottage the morning of the incident. She stated upon coming to work for the 11:00 PM shift she was advised by the employee she was relieving that Resident #17 did want to go inside, so she checked on her. She stated when Resident #17 wants to do something, she will do it. She stated that when she tried to get Resident #17 to go in she said she didn't want to go in and the Resident hit her . . forcibly, so she left her out and just checked on her. She stated she checked on her at 5:00 AM, spoke to her and she didn't want to come in. She further stated the last time she saw Resident #17 was around 6:45 AM.

An inquiry was made if she observed any changes in the resident's behavior or if there was anything abnormal that day or the previous days. She stated she did not. She stated that the way Resident #17 slapped her . . . when she tried to bring her in was not normal for her, but that the resident had injured other employees by doing so. She stated Resident #17 sat down quietly on the patio in a chair and that she did not see anything abnormal with Resident #17's behavior, as she was just sitting. She further stated the resident slept outside sometimes as she (and others) would walk all night. She further stated that at times law enforcement or the paramedics would be called to assist. She also stated that she was working alone in the cottage the night of the

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A 025	Continued From page 4	A 025		

incident, and that there is only one employee per cottage working the 11:00 PM to 7:00 AM shift.

A review of the facility's staffing scheduled revealed that there is only one employee working in each cottage during the 11:00 PM to 7:00 AM shift. Additionally, in an interview with the Administrator on at 2:42 PM, she stated there is 1 person per cottage for the 11:00 PM to 7:00 AM shift. She stated if they got two callouts, they would call someone in or have the 3:00 PM to 11:00 PM staff cover the shift.

In an interview conducted with the Administrator on at 2:35 PM, she stated there is no policy regarding residents staying outside, they are free to roam and that they can just go out and stay.

Observation of the entry/exit doors of the 7 cottages during the survey, it was observed the doors will open upon pressing the handle as they are not locked from the inside. When open, each door will open onto a courtyard with a cement patio/walkway and is fenced with an exit/entry gate that is secured by a magnetic lock that is controlled by a keypad.

In the interview conducted with the Administrator on at 2:35 PM, she stated that the only time the doors are locked is when a resident locks them. She further stated that as for supervision, frequent rounds are made to check on residents that are outside. She further stated she was not certain on how long the time was between the last time the employee saw Resident #17 alive, and when she was found expired. She further stated in the interview that in the days prior to her she was declining, but nothing that stands out more than normal. She stated she

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A 025	Continued From page 5 is said to have said "Goodbye" to some people, was less combative than normal. She further stated the employee should have called the Supervisor to inform her of the matter, and that they will do some in-services regarding it. The Administrator confirmed an Incident Report had not been completed related to the incident of Resident #17 being left outside all night and subsequently found expired in the morning. Further review revealed there was no evidence of documentation an attempt was made to contact the resident's family or Physician to advise of the situation of the resident refusing to come inside or any other attempts to encourage or redirect the resident to return inside. On the survey team met with the Administrator and Resident Care Director to conduct the Exit Conference. They were informed of and acknowledged the findings. Class III	A 025		
A 053	59A-36.008(4) FAC Medication - Administration (4) MEDICATION ADMINISTRATION. (a) For facilities that provide medication administration, a staff member licensed to administer medications must be available to administer medications in accordance with a health care provider's order or prescription label. (b) Unusual reactions to the medication or a significant change in the resident's health or behavior that may be caused by the medication must be documented in the resident's record and reported immediately to the resident's health care provider. The contact with the health care provider must also be documented in the resident's record.	A 053		

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A 053	Continued From page 6 (c) Medication administration includes conducting any examination or other procedure necessary for the proper administration of medication that the resident cannot conduct personally and that can be performed by licensed staff. (d) A facility that performs clinical laboratory tests for residents, including [illegible] testing, must be in compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) and Chapter 483, Part I, F.S. A valid copy of the federal CLIA Certificate must be maintained in the facility. A federal CLIA certificate is not required if residents perform the test themselves or if a third party assists residents in performing the test. The facility is not required to maintain a federal CLIA Certificate if facility staff assist residents in performing clinical laboratory testing with the residents' equipment. Information about the federal CLIA Certificate is available from the Laboratory and In-Home Services Unit, Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 32, Tallahassee, FL 32308; telephone (850)412-4500. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that the facility's Licensed Practical Nurse (LPN) failed to administrator medication in accordance with Physician Orders for 1 out of 2 residents receiving administration, specifically Resident #6. The findings included: During a medication observation conducted on at 11:00 AM, the medication pass was observed with LPN Staff D. LPN Staff D was observed reviewing the electronic Medication	A 053		

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A 053	Continued From page 7 Observation Record (eMOR) and obtaining the , for Resident #6. She obtained the reading for Resident #6. Based on the reading from the machine, it was noted the reading was 527. She immediately documented the reading in the eMOR system and then dialed the , to 35 units. She administered the 35 units of to Resident #6. Resident #6's eMOR for the month of was immediately reviewed after the administration of the . The eMOR revealed the following orders: kwik injection 100/mL (milliliters); , 100 units per mL inject 13 units , three times daily before meals. Additionally there was an order for an which read: Inject , before meals and at bedtime per 151-200=3U (units); 201-250=6U; 251-300=9U; 301-350=12U; BS> (greater than) 351=15U & repeat in 2 hours. If > 351 call MD. During an interview conducted with LPN Staff D on at 11:18 AM, Resident #6's orders were discussed. She stated she is aware of the current orders stating the resident is to receive 28 units, 13 units routinely and 15 units per the , however, she stated she administered 7 units more than the Physician Orders because the resident is always running high numbers. She stated she was going to call the Physician regarding his BS ( ) reading and that she would update this surveyor. In further discussion with her she stated that she routinely gives him extra and does not always contact the Physician. An inquiry was made why she is not contacting the Physician before administering extra units of	A 053		

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A 053	Continued From page 8 without a Physician Orders to which she had no response. LPN Staff D contacted the Physician at 12:30 PM on , and informed the Physician of Resident #6's levels which were 525. LPN Staff D informed the surveyor that the Physician stated, continue to observe resident, assess vital sign and retake reading in 1 hour. On at 1:15 PM, an observation was made of LPN Staff D taking the readings of Resident #6. At this time, the ARNP (Advance Registered Nurse Practitioner) arrived and observed the readings for Resident #6 to be 359. At this time, the ARNP took the resident to his room for further assessment. She returned to the Nursing Station around 1:45 PM, and gave new written orders for Resident #6. The new orders were as follows: Solos injection 100/ML Inject 25 units , daily (9AM) and Solos injection 100/ML Inject 50 units , at bedtime. Further review of Resident #6's eMORs for and , revealed the residents levels were above 351 more than 26 times and were taken by LPN Staff D. LPN Staff D was questioned again why she had not contacted Resident #6's Physician prior to regarding the levels being greater than 351 as ordered by the Physician per the . She provided no response. During an interview conducted with the Director of Nurses (DON) regarding LPN Staff D not following Physician Orders for the administration	A 053		

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A 053	Continued From page 9 of . . and administering additional . . without a Physician Order. The DON not was able to provide a response. Class III	A 053		
A 081	429.52(1 & 7) FS; 59A-36.011(. .) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously	A 081		

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A 081	Continued From page 10 completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to borne , , may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including	A 081		

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A 081	Continued From page 11 chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident . . . . ., neglect, and , . The facility must use its . . . . . prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.	A 081		

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A 081	Continued From page 12 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that 3 of 3 sampled direct care staff (Staff A, Staff B, and Staff C) completed the required mandatory training. The findings included: 1) Review of Staff A's employee file revealed she was hired on [redacted] as a Caregiver, and was observed assisting residents in the TV area, seating, serving, and attending to resident's needs. Review of her employee file revealed it did not contain the 2-hour Pre-Service Orientation as required prior to interacting with residents. 2) Review of Staff B's employee file revealed she was hired on [redacted] as a Caregiver and provides direct care to residents. The review also revealed that Staff B's employee file did not contain documentation of her training in Reporting Major Incidents and Adverse Incident training. 3) Review of Staff C's employee file revealed she was hired on [redacted] and provides direct care to Residents. The review also revealed that Staff C's employee file did not contain evidence of her receiving Policy and Procedure and Elopement Response Training. In an interview conducted with the Administrator on at 11:50 AM, she was notified of the missing training documentation for Staff A, Staff B and Staff C, and was provided an opportunity to review the employee's files for the documents.	A 081		

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A 081	Continued From page 13 In an interview conducted with the Administrator on at 12:25 PM, she stated there were no other training documents provided by Human Resources, and she was unable to find any documents showing completion of the missing trainings. No additional documentation was provided during the survey. Class III	A 081		
A 165	429.23(&) FS Risk Mgmt & QA 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;	A 165		

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PACIFICA SENIOR LIVING OF PALM BEACH	4760 JOG ROAD GREENACRES, FL 33467

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A 165	Continued From page 14 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal, or if the portal is offline, by electronic mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, through the agency's online portal, or if the portal is offline, by electronic mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) , neglect, or , must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that	A 165		

Agency for Health Care Administration

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A 165	Continued From page 15 must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board. (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to submit an Adverse Incident Report (AIR) as required following the of 1 of 4 sampled residents reviewed, specifically Resident #17. The findings included: During a complaint survey conducted from through , it was revealed the facility had an incident which involved the of a resident, Resident #17. A review of the End of Shift Report dated documented Resident #17 was left outside all night and was found lying on the	A 165		

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A 165	Continued From page 16 ground unresponsive by the incoming 7:00 AM to 3:00 PM shift. Local paramedics were called and were accompanied by local Law Enforcement. A review of the facility's Narrative Charting for Resident #17 revealed an entry dated . . . . . at 6:07 PM documenting Local Fire Rescue, Law Enforcement Sheriff and Crime Scene Investigator came to the facility and interviewed staff. There was no evidence an Adverse Incident Report (AIR) was submitted as required following the . . . . of Resident #17 and involvement of Law Enforcement. In an interview conducted with the Administrator on . . . . . at 2:29 PM, she was asked if an internal Incident Report was completed as a result of Resident #17 being left outside all night by herself and subsequently found . . the following morning. She was provided an opportunity to review the resident's file and could not locate it, confirming an internal Incident Report had not been completed. In a further interview conducted with the Administrator on . . . . . at 2:34 PM, she stated she was certain the State Agency responsible for investigating neglect and . . . . of the elderly came to the facility to inquire about the incident with Resident #17. However, this investigation would not be related to the Agency for Health Care Administration separate investigation and regulatory requirements. In an interview conducted with Caregiver Staff C on . . . . . at 9:41 AM, she stated Law Enforcement came to the facility regarding the . . . . , and they spoke with her regarding the incident.	A 165		

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A 165	Continued From page 17 In an interview conducted with the Administrator on [redacted] at 3:27 PM, she stated she did not do an Adverse Incident Report (AIR) because it (Resident #17's [redacted]) was not an accident or anything. She was reminded of the requirements for completing and submitting an AIR (1-day and 15-day report) to the Agency for Health Care Administration and was directed to the regulation covering it. She stated she understood. On [redacted] the survey team met with the Executive Director/Administrator and Director of Nursing to conduct the exit conference. They were informed of and acknowledged the findings. Class III	A 165		
CZ841	408.823( ) FS In-person Visitation (1) This section applies to , [redacted] centers as defined in s. 393.063, hospitals licensed under chapter 395, nursing home facilities licensed under part II of chapter 400, hospice facilities licensed under part of chapter 400, intermediate care facilities for the , , licensed and certified under part VIII of chapter 400, and assisted living facilities licensed under part I of chapter 429. (2)(a) No later than 30 days after the effective date of this act, each provider shall establish visitation policies and procedures. The policies and procedures must, at a minimum, include control and education policies for visitors; screening, personal protective equipment, and other control protocols for visitors; permissible length of visits and	CZ841		

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CZ841	Continued From page 18 numbers of visitors, which must meet or exceed the standards in ss. 400.022(1)(b) and 429.28(1)(d), as applicable; and designation of a person responsible for ensuring that staff adhere to the policies and procedures. Safety-related policies and procedures may not be more stringent than those established for the provider's staff and may not require visitors to submit proof of any . . . . . or immunization. The policies and procedures must allow consensual physical contact between a resident, client, or patient and the visitor. (b) A resident, client, or patient may designate a visitor who is a family member, friend, guardian, or other individual as an essential caregiver. The provider must allow in-person visitation by the essential caregiver for at least 2 hours daily in addition to any other visitation authorized by the provider. This section does not require an essential caregiver to provide necessary care to a resident, client, or patient of a provider, and providers may not require an essential caregiver to provide such care. (c) The visitation policies and procedures required by this section must allow in-person visitation in all of the following circumstances, unless the resident, client, or patient objects: 1. End-of-life situations. 2. A resident, client, or patient who was living with family before being admitted to the provider ' s care is struggling with the change in environment and lack of in-person family support. 3. The resident, client, or patient is making one or more major medical decisions. 4. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently . . . 5. A resident, client, or patient needs cueing or encouragement to eat or drink which was	CZ841		

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CZ841	Continued From page 19 previously provided by a family member or caregiver. 6. A resident, client, or patient who used to talk and interact with others is seldom speaking. 7. For hospitals, childbirth, including labor and delivery. 8. patients. (d) The policies and procedures may require a visitor to agree in writing to follow the provider's policies and procedures. A provider may suspend in-person visitation of a specific visitor if the visitor violates the provider's policies and procedures. (e) The providers shall provide their visitation policies and procedures to the agency when applying for initial licensure, licensure renewal, or change of ownership. The provider must make the visitation policies and procedures available to the agency for review at any time, upon request. (f) Within 24 hours after establishing the policies and procedures required under this section, providers must make such policies and procedures easily accessible from the homepage of their websites. This Statute or Rule is not met as evidenced by: Based on record review and staff interview the facility failed to ensure their Visitation Policy met the regulatory guidelines by including all required components of the regulation. The findings included: On at 3:15 PM, the Visitation Policy was requested from the Administrator. During an interview with the Administrator, she was made aware the Visitation Policy provided did not address the State Requirements regarding visitation guidelines established on , .	CZ841		

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CZ841	Continued From page 20 Further, the Visitation Policy was not available on the facility's homepage on their website as required. The policy failed to address the following required regulatory guidelines: control education for visitors; Screening and PPE (personal protective equipment); Consensual physical contact; The resident, client or patient is making one or more major medical decisions; A resident, client or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently ; A resident, client or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver; and a resident who used to talk and interact with others is seldom speaking. On the exit conference was held with the Administrator and Director of Nursing who were informed of the findings of the survey and the findings will undergo a Supervisory review and are subject to change. The were informed a report would be forwarded from the field office and they stated they understood. Unclassified	CZ841		