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
	AL11967572	A. BUILDING: _____ B. WING _____	08/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOUCH OF KLASS ALF	560 SW 60TH AVENUE PLANTATION, FL 33317

(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 and Generator Monitoring survey was conducted on at Touch Of Klass ALF. The facility had deficiencies identified related to the Relicensure at the time of the survey.	A 000		
A 054	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known ␣ the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical , the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the	A 054		

AHCA Form 3020-0001

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

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A 054	Continued From page 1 medication. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, it was determined that, the facility failed to maintain a Medication Observation Record (MOR) that reflected each time the medication was given to the resident. The facility failed to maintain a Medication Observation Record (MOR) that included the resident's healthcare provider's name and phone number for 2 of 3 sampled residents (Resident# 1 and 2). The findings included: A Medication Observation Record (MOR) must include the name, strength and direction of use of each medication, name of resident's healthcare provider and phone number. 1) During a medication audit on revealed facility MOR for Resident #1, dated through did not document the times of medication use for: - 100-10 milligram (mg), take 10 milliliters (ml) by every four hours for . Further review of the MOR revealed that from through the MOR was signed by facility staff, but it did not document that the medication was given every four hours and/or breakdown of four hours each dose. During an interview on at approximately 8:40 AM with Staff B (Caregiver) she confirmed she had assisted Resident #1 with her morning medication and acknowledged that the MOR did not reflect a breakdown of four times a day. Therefore, surveyor unable to confirm when the last time was recorded on the	A 054		

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A 054	Continued From page 2 MOR that the resident received her medication. 2) During a medication audit on revealed facility's MOR for Resident #2, dated through was a handwritten MOR that it did not document Resident #2's healthcare provider's name and phone number. During an interview with the Administrator on at approximately 9:05 AM she was informed of the concerns regarding Resident #1's MOR, it did not reflect four times a day every time the medication was given by facility staff. The Administrator was also informed regarding Resident #2 MOR was missing provider's information. She acknowledged the findings. Class III	A 054		
A 055	59A-36.008(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises. Residents may also store their medication in their rooms or apartments if either the room is kept locked when residents are absent or the medication is stored in a secure place that is out of sight of other residents. (b) Both prescription and over-the-counter medications for residents must be centrally stored if: 1. The facility administers the medication;	A 055		

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A 055	Continued From page 3 2. The resident requests central storage. The facility must maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that, because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents, or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident before admission as required in Rule 59A-36.006, F.A.C. (c) Centrally stored medications must be: 1. Kept in a locked cabinet; locked cart; or other locked storage receptacle, room, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration must be kept refrigerated. Refrigerated medications must be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which the refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration of medication, or administering medication. Such staff must have ready access to keys or codes to the medication storage areas at all times; and, 4. Kept separately from the medications of other residents and properly closed or sealed. (d) Medication that has been discontinued but has not expired must be returned to the resident	A 055		

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A 055	Continued From page 4 or the resident's representative, as appropriate, or may be centrally stored by the facility for future use by the resident at the resident's request. If centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication." Such medication may be reused if prescribed by the resident's health care provider. (e) When a resident's stay in the facility has ended, the administrator must return all medications to the resident, the resident's family, or the resident's guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident's medications are still at the facility, the medications are considered abandoned and may disposed of in accordance with paragraph (f). (f) Medications that have been abandoned or have expired must be disposed of within 30 days of being determined abandoned or expired and the disposal must be documented in the resident's record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (g) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was determined that, the facility failed to ensure the residents' medication was safe in a manner that was free of unsafe conditions and abnormal temperatures for Residents#1, 2, 3 and 4. The findings included:	A 055		

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A 055	Continued From page 5 Observations during tour conducted on between 9:30 AM and 1:00 PM revealed the laundry room (small room) had a washer, dryer, freezer and utility metal cabinet. Further observation revealed dryer was running and upon entering the room it was very warm. During an interview with the Administrator on at approximately 10:15 AM she acknowledged the dryer was running and the temperature in the room was very warm. At this time, she confirmed the medication for all the residents was stored inside the metal cabinet (corner of the room) next to the freezer (photo obtain). The Administrator was informed of the concerns regarding medication storage. She acknowledged the findings. Class III	A 055		
A 056	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (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: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no	A 056		

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A 056	Continued From page 6 individual other than a pharmacist may transfer medications from one storage container to another. (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, 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. (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. (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. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who	A 056		

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A 056	Continued From page 7 receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (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 manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (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. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide Physician's order for crush pills for 1 of 3 sampled residents (Resident #1). The findings included: During an interview on at approximately 8:35 AM with Staff B (Caregiver), she was asked if the facility has any residents	A 056		

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A 056	Continued From page 8 that required medication crush and she stated yes, Resident's #1, 3 and 4. At this time, she was asked to provide the facility's Medication Observation Record (MOR) photographic evidence was obtained. Record review of the MOR for Resident #1 revealed the following medication: a) , 50 milligrams (mg) tablet, take one tablet by once daily at noon. b) , 50 milligrams (mg) tablet, take 1.5 tablet (75mg) by at bedtime. Further review of the resident's MOR dated - revealed the MOR did not document crush pills/tablets for the medications mentioned above (photographic evidence was obtained). During an interview on at approximately 10:30 AM with Staff A (Administrator) she was informed to provide a medication order for crush pills for Resident #1 medications. Staff A stated the facility has a copy but unable to provide during survey. At this time, she confirmed the resident cannot swallow pills/tablets. During an interview with the Administrator on at approximately 3:50 PM she acknowledged the findings. No additional information was provided. Class III	A 056		
A 080	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility	A 080		

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A 080	Continued From page 9 staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements. (3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage of the core competency test. The required core competency test must cover at least the following topics: (a) State law and rules relating to assisted living facilities. (b) Resident rights and identifying and reporting , neglect, and , . (c) Special needs of elderly persons, persons with mental illness, and persons with , and how to meet those needs. (d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food. (e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication. (f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures. (g) Care of persons with 's and related . 59A-36.011 (1) ASSISTED LIVING FACILITY CORE TRAINING REQUIREMENTS AND COMPETENCY TEST. (a) The assisted living facility core training requirements established by the department	A 080		

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A 080	Continued From page 10 pursuant to section 429.52, F.S., shall consist of a minimum of 26 hours of training plus a competency test. (b) Administrators and managers must successfully complete the assisted living facility core training requirements within 3 months from the date of becoming a facility administrator or manager. Successful completion of the core training requirements includes passing the competency test. The minimum passing score for the competency test is 75%. Administrators who have attended core training prior to , and managers who attended the core training program prior to , , shall not be required to take the competency test. Administrators licensed as nursing home administrators in accordance with chapter 468, part II, F.S., are exempt from this requirement. (c) Administrators and managers shall participate in 12 hours of continuing education in topics related to assisted living every 2 years. (d) A newly hired administrator or manager who has successfully completed the assisted living facility core training and continuing education requirements, shall not be required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements will be considered a new administrator or manager for the purposes of the core training requirements and must: 1. Retake the assisted living facility core training; and, 2. Retake and pass the competency test. (e) The fees for the competency test shall not exceed $200.00. The payment for the competency test fee shall be remitted to the entity administering the test. A new fee is due each time the test is taken.	A 080		

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A 080	Continued From page 11 This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure the Administrator had completed 12 hours of continuing education. The findings included: During an interview on at approximately 8:50 AM the Administrator was informed to provide her employee file. Review of the facility's employee personnel file revealed that the Administrator was hired on . CORE training and Exam dated . Further review revealed no documentation in her file for continuing education (12 hours every two years). During an interview on at approximately 1:30 PM the Administrator was given an opportunity to provide documentation for her 12 hours of continuing education. During an interview on at approximately 3:50 PM the Administrator stated she believes she took the training but not able to provide documentation during survey. She acknowledged the findings. Class III	A 080		
A 081	429.52(1 & 7) FS; 59A-36.011( ) FAC Training - Staff In-Service 429.52	A 081		

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A 081	Continued From page 12 (1)(a) 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. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (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 081		

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A 081	Continued From page 13 (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously 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	A 081		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 081	Continued From page 14 the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including 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	A 081		

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	AL11967572	A. BUILDING: _____ B. WING _____	08/09/2025

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A 081	Continued From page 15 policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined that, the facility failed to ensure staff had completed Training for Nutritional and Safe Food Handling and Nutrition and Food Service Designee, for 3 of 3 sampled staff (Staff A, B and C). The findings included: 1) Review of the personnel file for Staff A (Administrator) with a hire date of revealed Staff A did not have documentation on Nutrition and Food Service Designee continuing education training of 2 hours and Nutritional Safe Handling in her file. 2) Review of the personnel file for Staff B (Caregiver) with a hire date of revealed Staff B did not have documentation on Nutritional and Safe food Handling in her file. 3) Review of the personnel file for Staff C (Caregiver) with a hire date of revealed Staff C did not have documentation on Nutritional and Safe food Handling in her file. During an interview on at approximately 3:50 PM the Administrator stated she was not aware of the training for Nutrition and Food Service Designee continuing education for 2 hours and Nutritional Safe Handling training for her and Staff B and C. At this time, she	A 081		

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A 081	Continued From page 16 acknowledged the findings. No additional documentation was provided. Class III	A 081		
A 152	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during	A 152		

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A 152	Continued From page 17 use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be . This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to establish and/or maintain a safe, clean and decent living environment free of hazards for 5 of 5 Residents (Resident #1, 2, 3, 4 and 5). The findings included: During a tour conducted on between 9:30 AM and 1:00 PM, this surveyor observed the following physical plan concerns: 1) Hallway ceiling between emergency food and medication storage (laundry area) had a big rectangle piece of popcorn sheetrock on the ceiling removed and put together and unfinished work (the piece was clearly recessed above the ceiling) and visible openings were showing pieces of wood from the attic (photo obtained). 2) Resident #3 room's wall behind the door had a fire emergency light device not properly installed on the wall also above fire device ceiling has a separation from the wall (photo obtained). 3) Bathroom near Resident's (2, 3 and 4) room revealed: a) an exit door that leads to the pool area, further observation revealed rotten wood door (at the bottom) and a hole in the bottom corner of the door. b) bathroom vanity doors and drawers with white	A 152		

Agency for Health Care Administration

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A 152	Continued From page 18 coating separating and pealing. (photos obtained). 4) Common area: glass sliding double door (that leads to the pool) missing door frame and door threshold (photo obtained). 5) Pool screening enclosure was ripped in sections (near sliding door and alongside the house) photo obtained. During an interview on with the Administrator at approximately 11:00 AM, she stated that the items mentioned above have to do with the facility's roof that leaked and a flood in the facility that occurred early this year (unable to provide date of the flood). She stated she is working with an insurance adjuster and the local City to have permits approved so she can start repairs at the facility. No additional documentation was provided to support ongoing roof repairs during the survey. Class III	A 152		

Agency for Health Care Administration

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ZZ841	408.823( ) FS In-person Visitation (1) This section applies to , 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 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	ZZ841		

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ZZ841	Continued From page 1 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 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,	ZZ841		

Agency for Health Care Administration

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ZZ841	Continued From page 2 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 interview, it was determined that, the facility failed to provide established Visitation Policies and Procedures requested by the surveyor at the time of the survey. The findings included: During a record review of the facility on , the Administrator was informed to provide a copy of the Visitation Policy and Procedures. Further review revealed the facility did not have any documentation to prove the facility has Visitation Policies and Procedures in place. During an interview with the Administrator on at approximately 1:50 PM the Administrator was given an opportunity to provide documentation regarding the facility Visitation Policies and Procedures. She acknowledged the findings. Class III	ZZ841		