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
	AL11970101	A. BUILDING: _____ B. WING _____	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASABLANCA ELITE ADULT CARE LLC	509 NW 103RD AVE PLANTATION, FL 33324

(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 Change of Ownership (CHOW) and Generator Monitoring survey was conducted on at Casablanca Elite Adult Care LLC. The facility had deficiencies identified related to the CHOW and Generator Monitoring at the time of the survey.	A 000		
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. (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 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	A 053		

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A 053	Continued From page 1 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, the facility failed to ensure that only licensed care staff administered medication. The findings included: A review of Resident #3's Health Assessment revealed a diagnose of , listed as bedridden, noted as total care for Activities of Daily Living and reflected Medication Administration was required. A.In an interview with Staff C (Caregiver) on at approximately 12:05 PM, Staff C stated Resident #3 was due for a , and with the packaged medication in was observed entering Resident #3's room. Upon exiting Resident #3's room, Staff C was observed with the now empty medication package in , and in concurrent interview, Staff C stated she had administered the to Resident #3. In a record review of Resident #3's Medication Observation Record (MOR) for , it was observed that the following medication order was handwritten in Spanish: Proctosoce supositorio - 10mg (proctoscope) English translation	A 053		

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A 053	Continued From page 2 Insti supositorio diario segun nesesario (Insert , , , daily as needed) English translation Further review of the MOR showed the medication had been administered by Staff C on , , , and . B. Record review of Resident #3's , Medication Observation Record (MOR) revealed , Tab 1mg is scheduled at 6:00 AM, 12:00 PM and 8:00 PM. Per MOR, Resident #3 was last given the medication on at 6:00 AM. Observations on at approximately 12:05 PM showed the following: Staff C (Caregiver) entered Resident #3's room with a medication cup containing the , Tab 1mg and a cup of water with a flexible straw. Resident #3 was on his in a hospital bed that was inclined to allow for Resident to be in a reclined, seated position. Resident #3's arms were bent at the and his were constricted into a position approaching a fist. Resident #3's were closed and he was not responsive to Staff C's greetings when entering the room. Staff C stood next to the bed and spoke loudly in Spanish to Resident #3, encouraging him to open his to eat. Resident #3 opened his . Staff C was observed to use the medication cup to pour the tablet into Resident #3's . Staff C then lifted the cup of water and placed the straw into Resident #3's . Staff C repeatedly told Resident #3 to drink, leaned over the bed and spoke into Resident #3's . When there was no response, Staff C shook Resident #3 by the repeatedly. When there was no response, Staff C rubbed Resident #3 on his	A 053		

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A 053	Continued From page 3 repeatedly. Staff C continued effort to wake Resident #3 for approximately 5 minutes without response. Staff C was then observed to use her gloved ˬ to remove the pill from Resident #3's and place it into the medication cup. In a concurrent interview, Staff C reported a plan to try again a little later. Observations on at approximately 1:25 PM showed the following: Staff C (Caregiver) entered Resident #3's room with a medication cup containing the ˌ Tab 1mg previously removed from Resident #3's and a cup of water with a flexible straw. Resident #3 remained on his in a hospital bed that was inclined to allow for Resident to be in a reclined, seated position. Resident #3's arms were bent at the and his ˬ were constricted into a position approaching a fist. Resident #3's ˛ were closed and he was not responsive to Staff C's greetings when entering the room. Staff C stood next to the bed and spoke loudly in Spanish to Resident #3, encouraging him to open his to eat. Resident #3 opened his . Staff C was observed to use the medication cup to pour the tablet into Resident #3's . Staff C then lifted the cup of water and placed the straw into Resident #3's . Staff C repeatedly told Resident #3 to drink, leaned over the bed and spoke into Resident #3's . When there was no response, Staff C shook Resident #3 by the repeatedly. When there was no response, Staff C rubbed Resident #3 on his repeatedly. Staff C continued effort to wake Resident #3 for approximately 5 minutes without response. Staff C was then observed to use her gloved ˬ to remove the pill from Resident #3's and place it into the medication cup. In a concurrent interview, Staff C stated a	A 053		

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A 053	Continued From page 4 plan to crush the , Tab 1mg in order to administer it to Resident #3 since she was unable to wake him to swallow it. It was observed Staff B (Assistant Administrator) was on site at the time of the above observations and is a licensed Advanced Practice Registered Nurse. Additionally, Staff A (Administrator) was available by telephone and is a licensed Registered Nurse. At no point did Staff C communicate medication pass issues with either Staff A or Staff B, and at no point did either reach out to Staff Upon Surveyor intervention, Staff B stopped attempted medication pass and stated that medication would not be given at this time. Staff B stated that if a resident is asleep, and unable to be woken, medication is not to be administered. On at approximately 3:25 PM, in an exit interview with Staff A and Staff B, the concerns regarding medication administration by an unlicensed caregiver were outlined. Class III	A 053		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable . The examination performed by the health care provider must have been conducted no earlier than 6 months before submission of the statement. Newly hired staff	A 078		

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A 078	Continued From page 5 does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of testing materials satisfies the annual examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of 2. If any staff member has, or is suspected of having, a communicable , such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility to provide services to residents must ensure that individuals providing services are qualified to	A 078		

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A 078	Continued From page 6	A 078		

perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents.
(e) For facilities with a licensed capacity of 17 or more residents, the facility must:
1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and,
2. Maintain time sheets for all staff.
(f) Level 2 background screening must be conducted for staff, including staff by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S.

This Statute or Rule is not met as evidenced by:
Based on record review and interview, it was determined, the facility failed to ensure a one time communicable status and
( ) status dated no more than 6 months prior to date of hire was documented in 4 out of 4 sample records reviewed (Staff A, B, C & D).

The findings included:

On , a review of employee records revealed the following:

Staff A (Administrator/Date of hire) communicable status one time statement was not included and status was dated , 7 months prior to hire date.

Staff B (Assistant Administrator/Date of hire) status was dated , 8 months prior to hire date.

Staff C (Caregiver/Date of hire) status was dated , 11 months prior to hire date.

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A 078	Continued From page 7 Staff D (Caregiver/Date of hire) status was dated , 16 months prior to hire date. On at approximately 3:25 PM, in an interview with Staff A and Staff B concerns regarding missing and outdated communicable status and status statements were reviewed. No additional documentation was provided. Class III	A 078		
A 080	429.52( ) FS; 59A-36.011(1) FAC Training - Core & Competency Test 429.52 (2) Administrators and other assisted living facility 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.	A 080		

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A 080	Continued From page 8 (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 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.	A 080		

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A 080	Continued From page 9 (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. This Statute or Rule is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure staff met the 12 hour bi-annual continuing education requirement for Core certification in 1 out of 2 records reviewed (Staff B). The findings included: A review of Staff B's (Assistant Administrator) with a date of hire of , employee record revealed an initial Core certificate reflecting 26 hours of training was issued and 12 hours of continuing education were completed . There was no record of continuing education in for 2020-2022, 2022-2024 or 2024-2026. On at approximately 3:25 PM, in interview	A 080		

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A 080	Continued From page 10 with Staff A (Administrator) and Staff B, Surveyor reviewed missing continuing education hours for Core certification. Staff B advised she was aware of the issue and was looking into retaking the Core exam. Class III	A 080		

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ZZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the , , are enrolled in the national retained print notification program at the Federal Bureau of Investigation: 1. A person with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. 2. Effective , , , or a later date as determined by the Agency for Health Care Administration, for the participation of qualified entities in the clearinghouse under s. 435.12, a person with a break in service of more than 90 days from a position for which screening is conducted by a qualified entity participating in the clearinghouse must submit to a national screening if the person returns to a position for which screening is conducted by a qualified entity. (c) An employer of persons subject to screening or a qualified entity participating in the clearinghouse must register with the clearinghouse and maintain the employment or affiliation status of all persons included in the clearinghouse. 1. Before , , , initial status and any changes in status must be reported within 10 business days after a person receives his or her initial status or after a change in the person ' s status has been made. 2. Effective , , , initial status and any changes in status must be reported within 5 business days after a person receives his or her initial status or after a change in the person ' s status has been made.	ZZ814		

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ZZ814	Continued From page 1 (d) An employer or a qualified entity participating in the clearinghouse must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee or a person with a current or potential affiliation with a qualified entity for electronic , submission to the Department of Law Enforcement. The registration must include the person ' s full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined, the facility failed to ensure employed staff were registered under the facility on the Background Screening Clearinghouse, for 14 out of 16 sampled employee records reviewed (Staff A, B, E, F, G, H, I, J, K, L, M, N, O & P). The findings included: A. On a record review of the Background Screening Clearinghouse employee roster for the facility revealed that Staff A (Administrator - Date of hire) and Staff B (Assistant Administrator - Date of hire) were not registered under the facility. B. Additional record review revealed the roster included 12 people (Staff E, F, G, H, I, J, K, L, M, N, O & P) not listed on the facility's staffing schedule and that were no longer employed. These individuals were listed as active employees	ZZ814		

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ZZ814	Continued From page 2 for the facility with no end date. On at approximately 3:25 PM, in an interview with Staff A and Staff B, Staff A confirmed the only employees of the facility are Staff A, B, C, & D. Unclassified	ZZ814		
ZZ816	408.809(2) 435.05(2) 59A-35.090(2d-3b) Background Screening-Compliance Attestation 408.809 Background screening; prohibited offenses.- (2) Every 5 years following his or her licensure, employment, or entry into a contract in a capacity that under subsection (1) would require level 2 background screening under chapter 435, each such person must submit to level 2 background rescreening as a condition of retaining such license or continuing in such employment or contractual status. For any such rescreening, the agency shall request the Department of Law Enforcement to forward the person's , to the Federal Bureau of Investigation for a national criminal history record check unless the person's , are enrolled in the Federal Bureau of Investigation's national retained print notification program. If the , of such a person are not retained by the Department of Law Enforcement under s. 943.05(2)(g) and (h), the person must submit , electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the , to the Federal Bureau of Investigation for a national criminal history record check. The , shall be retained by the Department of Law Enforcement under s.	ZZ816		

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ZZ816	Continued From page 3 943.05(2)(g) and (h) and enrolled in the national retained print notification program when the Department of Law Enforcement begins participation in the program. The cost of the state and national criminal history records checks required by level 2 screening may be borne by the licensee or the person . The agency may accept as satisfying the requirements of this section proof of compliance with level 2 screening standards submitted within the previous 5 years to meet any provider or professional licensure requirements of the Department of Financial Services for an applicant for a certificate of authority or provisional certificate of authority to operate a continuing care retirement community under chapter 651, provided that: (a) The screening standards and disqualifying offenses for the prior screening are equivalent to those specified in s. 435.04 and this section; (b) The person subject to screening has not had a break in service from a position that requires level 2 screening for more than 90 days; and (c) Such proof is accompanied, under penalty of perjury, by an attestation of compliance with chapter 435 and this section using forms provided by the agency. 435.05 Requirements for covered employees and employers.-Except as otherwise provided by law, the following requirements apply to covered employees and employers: (2) Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if for any of the disqualifying offenses while employed by the employer.	ZZ816		

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	AL11970101	A. BUILDING: _____ B. WING _____	04/07/2026

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ZZ816	Continued From page 4 59A-35.090 Background Screening. (d) Attestation of Compliance with Background Screening Requirements, AHCA Form 3100-0008, , , herein incorporated by reference, must be completed by the individual and retained by the provider upon hire to attest that they meet the requirements for qualifying for employment, they have not been unemployed for more than 90 days from a position that requires Level 2 screening, and they agree to inform the employer immediately if for any disqualifying offense. The Attestation of Compliance is available at https://www.flrules.org/Gateway/reference.asp?No=Ref-17724, and available from the Agency for Health Care Administration's website at: https://ahca.myflorida.com/health-care-policy-and-oversight/bureau-of-central-services/background-screening/additional-information/regulations. (e) An administrator or chief financial officer must be screened and qualified prior to , , to the position. (3) Results of Screening and Notification. (a) Final results of background screening requests will be provided through the Agency's secure website that may be accessed by all health care providers applying for or actively licensed through the Agency that are registered with the Care Provider Background Screening Clearinghouse. The secure website is located at: apps.ahca.myflorida.com/SingleSignOnPortal. (b) If a Level 2 criminal history is incomplete, correspondence will be sent to the individual being screened requesting the report and court disposition information. Pursuant to Section 435.05(1)(d), F.S., the missing information must be filed with the Agency within 30 days of the Agency's request or the individual is subject to disqualification in accordance with Section	ZZ816		

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ZZ816	Continued From page 5 435.06(3), F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, it was determined, the facility failed to ensure a completed and signed Background Screening Compliance Attestation was included in the record for 1 out of 4 sampled records reviewed (Staff B). The findings included: A review of the employee record for Staff B (Assistant Administrator) with a date of hire of , revealed no record of signed Background Screening Compliance Attestation. On at approximately 3:25 PM, in an interview with Staff A (Administrator) and Staff B, missing Background Screening Compliance Attestation was reviewed. No additional documentation was provided. Unclassified	ZZ816		
ZZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (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 management plan to the local emergency management agency, county health department, or Department of Health as follows:	ZZ830		

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ZZ830	Continued From page 6 (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. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (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. (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. (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: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period	ZZ830		

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ZZ830	Continued From page 7 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. (4) . . . 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. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit their Comprehensive Emergency Management Plan (CEMP) to the county emergency planning department for review and approval within thirty days after a Change Of Ownership (CHOW).	ZZ830		

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ZZ830	Continued From page 8 The findings included: On Staff A (Administrator) presented a CEMP document from the countyaddressed to the facility's previous owner that was issued and reflected plan approval through . Review of the facility's provisional license for a CHOW shows the license was initiated on when the change of ownership occurred. During review of facility records, there was no documentation to show that the CEMP had been submitted to the county when the change of ownership occurred. In an interview with Staff A by phone at approximately 2:00 PM the out of date CEMP was discussed. The facility provided no additional documentation for review at this time. Unclassified	ZZ830		
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	ZZ841		

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ZZ841	Continued From page 9 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 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	ZZ841		

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ZZ841	Continued From page 10 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, 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 ensure the visitation policy on their website met regulations. The findings included: On a record review of the facility's website revealed the visitation policy did not include statement it would allow for in-person	ZZ841		

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ZZ841	Continued From page 11 visitation in all required circumstances. On at approximately 3:25 PM, in an interview with Staff A (Administrator) and Staff B (Assistant Administrator) concerns regarding missing information on Visitation Policy was outlined. No additional documentation was provided. Unclassified	ZZ841		