

Southern Gardens FL AL Management LLC

Assisted Living License #8937

The Gardens of Lake Alfred Visitation Policy

Policy:

It is the policy of the facility to ensure safe visitation to our residents consistent with the residents "Bill of Rights" F.S.429.28. In addition, to educate employees and visitors of residents on procedures related to infection control, screening, personal protective equipment, and other infection control protocols.

Procedures:

- 1. This Facility will ensure that in person visitation will be allowed unless the resident objects. Visitation will be allowed for any length of time within normal visitation hours. There is no limit on the number of visitors the resident may have.**
- 2. The facility will provide immediate access to any resident by:**
 - . Any representative of the Secretary of HHS;
 - . Any representative of the State of Florida;
 - . Any representative of the Office of the State Long Term Care Ombudsman;
 - . The resident's physician;
 - . Any representative of the protection and advocacy systems, as designated by the State of Florida, and as established under the Developmental Disabilities Assistance and Bill of rights of 2000;
 - . Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder as established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000;
 - . The resident representative; or
 - . Immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time.
- 3. The administrator is designated as the person responsible for ensuring that staff adhere to the visitation policies and procedures.**

4. **Each resident /representative shall receive a copy of this facility's policies and procedures for visitation.**
5. **The facility will respect the right of the resident to determine the number of visitors he/she would like to have at any given time during the 9am-9pm visiting hours.**
6. **The facility will designate a staff member to support infection control and prevention by providing information on the visitation policy to the visitors.**
7. **Visitation will be from 9am-9pm, at a minimum. Visitors requesting to come any other time need to make arrangements with the administration or designee in advance.**
8. **The Facility will not require visitors to provide proof of vaccination.**
9. **Visitors and residents may choose to remove their masks when visiting in private areas away from others, such as resident rooms when roommate is not present.**
10. **Residents are permitted consensual physical contact between residents and visitors.**
11. **Visitors may eat with a resident if the resident (or representative) and the visitor are aware of the risks and adhere to the core principles of infection prevention. Eating in a separate area is preferred, however if that is not possible, then the meal could occur in a common area as long as the visitor, regardless of their vaccination status, is physically distanced from other residents and wears a mask, except while eating or drinking. If the visitor is unable to physically distance from other residents, they should not share a meal with the resident in a common area. Visitors, regardless of vaccination status, must wear masks and physically distance from other residents and staff when in a communal area in the facility.**
12. **In rare circumstances when an outbreak may be uncontrolled and the facility has been working with the local health department to stop the outbreak, visitation may be paused at the direction of the health department. If the outbreak is severe enough to warrant pausing visitation, it would also warrant a pause on accepting new admissions (as long as there is adequate alternative access to care for hospital discharges).**

13. The visitation policy allows in-person visitation in all of the following circumstances, unless the resident, client, or patient objects:

- A. End-of-life situations.
- B. 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.
- C. The resident, client, or patient is making one or more major medical decisions.
- D. A resident, client, or patient is experiencing emotional distress or grieving the loss of a friend or family member who recently died.
- E. A resident, client, or patient needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver.
- F. A resident, client, or patient who used to talk and interact with others is seldom speaking.

Resident Authorized Visitors Designation

I, _____ designate the following person(s) as authorized visitors 7 days a week, between the hours of 9am- 9pm. As either an Essential Caregiver or General Visitor as indicated to the right of each name:

Name Guest	Essential Caregiver	General
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand I will need to give written notice to the facility staff to change the above designations.

Name: _____

Signature: _____

Date: _____

**EMPLOYEE'S ACKNOWLEDGEMENT OF RESPONSIBILITY
IN-PERSON VISITATION SCREENING AND INFECTION CONTROL
PROCEDURES**

Employee's Name _____ Position: _____
Title _____

My signature below verifies that I was educated on this Assisted Living
Residence

Policies and procedures on INFECTION IN- PERSON VISITATION AND INFECTION
CONTROL PROTOCOLS as specified by Senate Bill 988, April 2022.

In addition, I understand and will execute my responsibilities as follows:

1. Ensure adherence to the Residents Bill of Rights at a minimum visiting
hour 9:00AM-9:00PM Daily.
2. To ensure that essential caregivers (visitors) are not required to provide
necessary care to residents.
3. Support infection prevention and control education of visitors on use of
PPE, Use Masks, and hand sanitation.

Date of Training: _____ Name of Trainer _____ Title _____

Employee's Signature: _____ Date: _____

Administrator's/Designee's Name: _____ Date: _____

CERTIFICATION OF EDUCATION FOR VISITORS OF RESIDENTS

Topics:

1. FACILITY SCREENING PROCESS
2. INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES
3. USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE), MASKS.
4. HAND SANITATION

STATEMENT OF COMPLETION

FACILITY'S NAME: _____

The signature below verifies that the resident's visitor received education on the above listed topics.

VISITOR'S NAME: _____ Date: _____

STAFF NAME: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT AND CONSENT TO COMPLY

My dated signature below verifies that I received, read, and understand the facility's Policies and Procedures on Infection Control and In-Person Visitation. I consent to be screened by this facility's staff and will comply with the policies and procedures upon arrival and while visiting resident (s) at this Assisted Living Residence.

I also understand that, if facility staff observes any form of non-compliance on my part, my visit may be suspended for violating the facility's in-person visitation policy and procedures.

VISITOR'S SIGNATURE: _____ DATE: _____

VISITATION TYPE: Essential Caregiver _____ General _____

DESIGNATED BY Resident: ☐ YES ☐ NO

COVID-19 VISITOR'S Screening Tool

****HRA Travel and COVID-19 Exposure Questionnaire (Revised 3/16/20)**

Rationale: There is no reliable way to distinguish coronavirus symptoms from symptoms caused by the common flu, as both diseases can cause, fever coughs, and pneumonia in severe cases. One of the greatest difficulties with the illness is that an individual may have been exposed to it and not exhibit any outward symptoms for a period of up to approximately two weeks. This form will identify individuals who may have been exposed to the virus.

Standard: All associates and visitors are asked as a precautionary measure to complete a questionnaire to ascertain potential exposure to COVID-19 to survey for heightened risk.

1. Have you recently travelled overseas to any of the following countries 14 days or less: China, Iran, South Korea, Italy, Japan, or Hong Kong?
Yes or No?
2. Is it less than 14 days since you had close personal contact with anyone who has travelled to any of the above places?
Yes or No?
Close personal contact is defined as conversing with someone for more than 15 minutes at 3 feet or less.
3. Have you recently traveled on a cruise ship within the past 14 days?
Yes or No?
4. Have you been infected with the coronavirus disease (COVID-19) and have not had two consecutive negative test results separated by 24 hours?
Yes or No?
5. Do you have a new onset or worsening of any of the following symptoms: fever, cough, nausea, vomiting, diarrhea, shortness of breath, or any other respiratory infection?
Yes or No?
6. Have you traveled through any airport within the past 14 days?
Yes or No?

Visitor's Name: _____ Date: _____
Screening Staff Member: _____ Signature (Staff Member): _____

Response: if answer "yes" to any questions and exhibiting symptoms associated with the coronavirus, the community will disallow nonessential visits/work until illness resolved/cleared by MD. In addition, following steps are initiated: individual will contact MD for clinical assessment in accordance with CDC guidelines for "Evaluating and reporting Person Under Investigation" to determine whether they meet criteria for testing for COVID-19 Revised June 2022