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
	AL11965661	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS LAKE MARY	3655 W. LAKE MARY BLVD. LAKE MARY, FL 32746

(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 Complaint Investigation #2019015305 was conducted on [redacted] and [redacted]. Spring Hills Lake Mary had deficiencies at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents 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.	A 025		

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A 025	Continued From page 1 (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 observations, record reviews and interviews, the facility failed to follow a health care provider's order for 1 of 3 sampled residents (#1), and failed to appropriately intervene and follow the health department's recommendations to prevent the spread of . . . . . . Findings: A complaint was received by the Agency for Health Care Administration (AHCA) that indicated the facility had a positive case of . . . . . , failed to report the case to the Health Department in a timely manner, failed to follow the Health Department's recommendations, and failed to notify the health department when the hot water heater broke during the treatment phase. On at 9:37 a.m., a sign was posted on the entrance door to the memory care unit that read, "have had residents who have experienced a . . that is . . . . . Please be advised that this comes from skin to skin contact." There	A 025		

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A 025	Continued From page 2 were no additional postings seen. At 9:40 a.m. on . . . . . , housekeeper A said she's been employed for six years and consistently works in memory care. She said she was not told of any concerns, that she knew only because she read the sign posted on the door. She said she was not instructed to do any special cleaning. At 10 a.m. on . . . . . , caregiver B said approximately one month ago, she went to a health center for a . . and was diagnosed with . At 10:09 a.m. on , laundry staff D said she was told to wash the resident's clothes with bleach and hot water when the rashes were present, and she waited until the hot water was working before she finished the resident's rooms. Review of email correspondence between the Director of Resident Care (DRC) and the health department revealed that on , the DRC made an email notification of one confirmed resident case of and one reported family case. Among other things, the recommendations from the Health Department included: Notify the Agency. Continue to monitor all residents and document weekly skin sweeps for all residents for twelve weeks. Treat all residents and staff with the appropriate prophylaxis at the same time. Post signs at all entrances to inform visitors of the outbreak for at least 6 weeks. Make sure that the towels are only used once and washed in hot water and dried in a hot dryer.	A 025		

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A 025	Continued From page 3 An extra training on . . . . control for all staff is also necessary to enforce contact precautions. The DRC indicated in two separate emails that the residents were all treated on . . . . . . At 10:45 a.m. on . . . . . , the administrator confirmed the only posted sign was the one on the memory care entrance door. He said the Health Department only indicated to post on that door. When the recommendations were discussed with him, he said he did not know about posting multiple signs, and said the recommendations were provided to the DRC and not to him. Resident #1's record revealed a facility admission date of . A current 1823 health assessment form, dated . . . . , indicated that her diagnoses include 's and she requires medication administration. A facility note, dated . . . . . , indicated that she "has a continuing ". She had a . . . . visit on . . . . . , and a skin . . . obtained at that time was positive for . 5% . . . cream was ordered to apply to entire body and wash off hours after. On , she had a . follow up visit and . . . . . 3 milligrams (mg.) was prescribed to give four tablets every other week for 2 weeks, ... 5% . . . cream one application once a day, and recommended sanitation of all clothing and linens as per CDC guideline as well as contact isolation until treated. On , she had a . follow-up visit and the note indicated that her had significantly improved after she was treated, and	A 025		

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A 025	Continued From page 4 indicated that "she received cream x 2 doses and x 2 doses". However, review of her and Medication Observation Records (MORs) revealed documentation to indicate that she received only one application of the , and she did not receive the second application or any of the , as prescribed. At 2:10 p.m. on , the DRC confirmed the resident was not fully treated for the , as prescribed, and said the orders were filed in the wrong section of the chart and therefore were not seen. Resident #3's record revealed a facility admission date of . A current 1823 health assessment form, dated , indicated that her diagnoses included 's and she requires assistance with self-administration of medications. A health care provider's order, dated , indicated to start 5% cream, apply cream from the to the soles of , leave on overnight and wash off in 12 hours for Pruritic /, , . Skin , , results, dated , indicated that she had . A visit note indicated the same and treatment was prescribed. At 2:50 p.m. on , the director of environmental services said he was informed approximately one week ago of the concerns with , was not instructed to change any of the cleaning and laundry processes, the facility did not have hot water from through and at that time, the resident's dark clothes were	A 025		

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A 025	Continued From page 5 washed in water and the white ones were bagged and left in the resident's rooms until the hot water was fixed. At 3:15 p.m. on , a Health Dpartment representative indicated they were unaware of resident #3's positive , in . At 3:25 p.m. on , with the administrator and DRC, the administrator said he never knew AHCA had to be informed of the . However, the DRC said she told the administrator this was an instruction from the Health Department. They both said the Health Department was not notified when the hot water heater broke to receive information on alternate methods of sanitation. The DRC was unable to provide documentation to indicate the Health Department was notified of resident #1's positive case prior to . The DRC said not all of the residents were treated , as she indicated in her emails, and none of the staff were offered treatment or treated. She was unable to provide documentation to indicate weekly skin sweeps were conducted, and said she was in the process of training the staff on control. At 3:30 p.m. on , the DRC said the health department was not informed when resident #3 tested positive for because she did not know of this case until it was brought to her attention at the tiem of the survey. On at 2:40 p.m., the physician's assistant who conducted the follow-up visit with resident #1 on said he visited the resident again today and ordered more because her is persistent and her	A 025		

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A 025	Continued From page 6 . . . are crusty which is indicative of the need to give more medicine. He said he assumed the resident received the full treatment simply because it was ordered, did not know it was not given, and said it explained what he observed on her today. Photographic evidence obtained Class II	A 025		
A 030 SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline	A 030		

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A 030	Continued From page 7 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . . , neglect, and . ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which	A 030		

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A 030	Continued From page 8 residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other	A 030		

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A 030	Continued From page 9 similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making , , for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is	A 030		

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A 030	Continued From page 10 harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without [illegible], interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, [illegible], and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder [illegible] Hotline operated by the Department of Children and Families, and, if applicable, [illegible], Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are	A 030		

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A 030	Continued From page 11 kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to follow its control policy and procedure for 2 of 3 sampled staff (B & E). Findings: The facility's control policy and	A 030		

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A 030	Continued From page 12 procedure indicated that staff will receive training on / as an annual refresher. Caregiver B was hired on . . . . . Her personnel record contained an control training, dated . . . . . Caregiver E was hired on . . . . . Her personnel record contained an control training, dated . . . . . Neither personnel record contained documented evidence to indicate they received annual . . . . . control training, as indicated in the facility's policy. On at 3:35 p.m., the administrator confirmed the findings and was unable to provide additional documentation. Photographic evidence obtained. Class III	A 030		