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
	AL11968119	A. BUILDING: _____ B. WING _____	12/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACE AT IVEY ACRES OF JAY	3964 FLORIDA AVE JAY, FL 32565

(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 focused control survey was conducted on - at The Terrace at Ivey Acres of Jay. Deficient practice was identified at the time of the survey.	A 000		
A 030 SS=I	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 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.	A 030		

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A 030	Continued From page 1 (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 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	A 030		

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A 030	Continued From page 2 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 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	A 030		

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A 030	Continued From page 3 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 harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must be set forth in writing and	A 030		

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A 030	Continued From page 4	A 030		

provided to the resident or the resident's legal representative. The notice must state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. 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 , 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, , 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 Hotline operated by the Department of Children and Families, and, if applicable, , 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

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A 030	Continued From page 5 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 observation and interviews, the facility failed to provide a safe living environment to prevent the spread of Coronavirus 2019 (COVID-19) by failing to have policies in place to address COVID-19 positive residents from coming into contact with negative residents, visitors, or staff and to address appropriate personal protective equipment for all staff coming	A 030		

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A 030	Continued From page 6 into contact with COVID-19 positive residents. Per the Centers for Control and Prevention (CDC), the COVID-19 is a transmissible that presents severe risk to persons who are aged, infirm, or suffer from co- including, but not limited to, system deficiency, , , , and . This failure has the potential to affect all 51 residents in the facility. On , the Governor of the State of Florida issued Executive Order 20-51 designating a Public Health Emergency as a result of COVID-19 and its impact. Pursuant to that authority, emergency orders have been issued by the Florida Division of Emergency Management to implement the protections necessary to assure the health, safety, and well-being of Florida's citizenry, including those most to the effects of . The Agency for Health Care Administration (AHCA) has issued guidance and clarification on DEM Order 20-006 to providers, and on , issued an alert notifying nursing homes that all staff or other individuals admitted to a residential facility must don masks and that caregivers must wear gloves when providing resident care. While the treatment and management of residents with and the implementation of isolation precautions for such events are long-standing health care issues faced by residential facilities, the ease of contagion and the effects of presented by COVID-19 mandate that providers exert meticulous practice and procedure to identify resident symptoms and take immediate procedures to both assure	A 030		

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A 030	Continued From page 7 appropriate treatment of a potentially resident and protect the remainder of a facility's population from the risk of spread of the . On , the Governor issued Executive order 20-316 which extended EO 20-52 (including DEM Order 20-006 & DEM Order 20-011) through . According to the CDC's Internet website, last updated on , retrieved on from https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html, "Given their congregate nature and population served, assisted living facilities (ALFs) are at high risk for SARS-CoV-2 spreading among their residents. If with SARS-CoV-2, the that causes COVID-19, assisted living residents - often older adults with underlying medical conditions - are at increased risk for severe illness." The findings include: On at approximately 10:05 AM, resident #1 was observed sitting in the main lobby of the building by the entrance and not wearing a mask. Three female residents were observed sitting side by side approximately 6 away from resident #1. One of the female residents was wearing a mask and the other two were not wearing masks. Staff member A, a medication technician and patient aide, was observed talking to the three females and explaining the need to wear masks and stay in their rooms. The three female residents were observed to leave the area and move toward the resident rooms. Resident #1 was observed for approximately 15 minutes and at no time did any staff member attempt to redirect him to wear a mask or return to his room. An interview was initiated during the observation	A 030		

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A 030	Continued From page 8 at approximately 10:20 AM, with the Director of Nursing (DON) and staff member A, regarding why resident #1 did not have a mask. Staff member A explained that resident #1 about frequently and leaves his mask behind. The DON stated that resident #1 "gets up and tries to pack his things to go home every morning and sits near the entrance". When pointing out that resident #1 did not appear to have a mask to put on and no attempt had been made to redirect resident #1, staff member A said "well, we can't tie him to his bed. We've tried to reach his family to come and pick him up." At this time, the DON was asked how the COVID-19 positive residents in the facility were . . . . . and the DON pointed to resident #1 and said, "we can't really them." At this time, the DON was asked about resident #1's COVID-19 status and confirmed resident #1 was positive for COVID-19. The DON was asked what measures had been attempted to . . . . . resident #1 and help him comply with mask wearing and social distancing from other residents. The DON explained again attempts were in progress to contact resident #1's family to have him taken out of the facility. During an interview at approximately 10:30 AM, the DON agreed the facility was aware COVID-19 positive residents were not isolating in rooms, and not wearing masks. She further stated that the facility policy did not specify appropriate personal protective equipment (PPE) for staff encounters with COVID-19 positive residents and did nor did it specify prevention of others from coming into contact with COVID-19 positive residents who refused to in their rooms. At approximately 10:49 AM, resident #1 was observed sitting in a chair in the main lobby near the entrance with no mask on. Resident #2 was	A 030		

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A 030	Continued From page 9 observed to come by resident #1 wearing only a surgical mask. There were no staff present at this time to redirect any other residents from resident #1 to protect them from being exposed to COVID-19. At approximately 10:55 AM, an observation was made of resident #4 walking in the hallway with no mask on and asking for someone to take her outside. The DON found a staff member to assist resident #4 to her room. The staff member who assisted was wearing a surgical mask and gown, but no protection and no N95 mask. Resident #4 was exposed to COVID-19 through a positive roommate and at the time of the observation was on precautionary isolation precautions. During an observation made with the DON at 11:10 AM, resident #1 was observed walking around the common area near the front lobby, walking around the fireplace and to a set of double doors leading to a courtyard. The DON approached resident #1 and attempted to get him to return to his room, but he refused. Resident #1 returned to the chair in the common area near the Christmas tree and at approximately 11:13 AM, a housekeeper approached wearing a gown and surgical mask, no protection and no N95 mask. The DON directed the housekeeper to assist resident #1 to his room. After informing the DON that the housekeeper was not wearing recommended PPE for working with COVID-19 positive residents, the DON agreed, but continued to encourage the housekeeper to take resident #1 to his room, stating that she would make sure the housekeeper was provided with the appropriate PPE after returning resident #1 to his room.	A 030		

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A 030	Continued From page 10 At approximately 11:15 AM, during the observations near the front lobby with the DON, a visitor was observed walking up to the lobby from the resident rooms in the 400 hallway and leaving the building wearing a surgical mask and no [illegible] protection. The DON identified the visitor and explained that she was here to visit her mother who is on hospice care. The DON was asked if there is a procedure in place to ensure the residents who in the halls and have COVID-19 are not entering other resident rooms. The DON said the residents were encouraged to lock the doors of their rooms because only the resident and staff have a key to their own rooms. When pointed out to the DON that rooms were observed to have doors open, she did not have an explanation, but said the facility doesn't have the staff to post someone in the hall to ensure the [illegible] behavior is monitored. When asked how compassionate care visitors in the facility or third party staff such as hospice, or even surveyors were alerted to the risk that a resident was potentially [illegible] and [illegible] without personal protective equipment, the DON had no answer. At approximately 11:25 AM, resident #3 approached the DON at the front desk in the common area of the front lobby and was not wearing a mask. The DON encouraged resident #3 to return to her room and resident #3 walked down hall toward room. During this observation, at 11:35 AM, resident #1 approached the front desk counter and leaned on the counter. Resident #1 was not wearing a mask and placed his [illegible] on the counter with his clasped and said, "someone needs to take me to get groceries." The DON spoke with resident #1 and convinced him to	A 030		

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A 030	Continued From page 11 return to his room after a few minutes. While the DON was assisting resident #1 to his room, resident #4, also confirmed to be COVID-19 positive approached the front desk while wearing a mask only covering her [illegible] and [illegible]. On [illegible] at approximately 4:00 PM, during a telephone interview, the administrator agreed no measures to prevent other residents, staff or visitors having contact with COVID-19 positive residents outside of rooms had been put into place. A review of a document provided by the facility in response to a request for an [illegible] control policy included an undated 2 page recommendation from the Centers for [illegible] Control and Prevention (CDC) titled " Control Reminders for Long Term Care per CDC Guideline." The document included bold-typed instructions to restrict personnel with [illegible] or symptoms to their rooms. Instructions included residents with [illegible] should wear a facemask when out of room, if tolerated, or use tissues to cover the [illegible] and [illegible]. The second page of the policy included examples of how to safely remove PPE. The policy did not include specific instructions for staff on when and where to don/doff certain types of PPE. A review of CDC recommendations titled "Considerations for Preventing the Spread of COVID-19 in Assisted Living Facilities" retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html on [illegible] at 2:59 PM, revealed "For situation where close contact with any ([illegible] or [illegible]) resident cannot be [illegible], personnel should at a	A 030		

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A 030	Continued From page 12 minimum, wear: , , protection (goggles or shield) and a N95 or higher-level , (or a facemask if , are not available. If personnel have direct contact with a resident, they should also wear gloves. If available gowns are also recommended..." Class II	A 030		