

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968269</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/15/2021</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**SARAH HOUSE III, THE**

**1001 OLD TOMOKA RD  
ORMOND BEACH, FL 32174**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| {A 000}                  | Initial Comments<br><br>A follow-up visit to a biennial survey was conducted at Sarah House III from ..... to ..... Deficient practice identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | {A 000}             |                                                                                                                          |                          |
| A 010                    | 429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency<br><br>429.26<br>(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:<br>(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.<br>(b) A facility may admit or retain a resident who requires the use of assistive devices.<br>(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the | A 010               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>SARAH HOUSE III, THE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1001 OLD TOMOKA RD<br/>ORMOND BEACH, FL 32174</b>                            |                          |                                                                    |
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| A 010                                                           | <p>Continued From page 1</p> <p>resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.</p> <p>(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:</p> <ul style="list-style-type: none"> <li>a. Move, turn, or reposition without total physical assistance;</li> <li>b. Transfer to a chair or wheelchair without total physical assistance; or</li> <li>c. Sit safely in a chair or wheelchair without personal assistance or a physical _____.</li> </ul> <p>2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.</p> <p>3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.</p> <p>(2). A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.</p> <p>(3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial</p> | A 010                                                                          |                                                                                                                          |                          |                                                                    |

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| A 010                                                           | <p>Continued From page 2</p> <p>examination for admission purposes may not have financial interests in the facility.</p> <p>59A-36.006</p> <p>(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a _____ medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:</p> <p>(a) The resident may be bedridden for no more than 7 consecutive days.</p> <p>(b) A resident requiring care of a _____ may be retained provided that:</p> <ol style="list-style-type: none"> <li>1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,</li> <li>2. The condition is documented in the resident's record; and,</li> <li>3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility.</li> </ol> <p>(c) A _____, ill resident who no longer meets the criteria for continued residency may continue</p> | A 010                                                                          |                                                                                                                          |  |                                                                    |

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| A 010                                                           | <p>Continued From page 3</p> <p>to reside in the facility if the following conditions are met:</p> <ol style="list-style-type: none"> <li>1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need;</li> <li>2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency;</li> <li>3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and,</li> <li>4. Documentation of the requirements of this paragraph is maintained in the resident's file.</li> </ol> <p>(d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times.</p> <p>(e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license.</p> <p>(f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training.</p> <p>(g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure residents met the criteria for continued admission for one of three sampled residents (Resident #3).</p> | A 010                                                                                         |                                                                                                                          |                                                                    |

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**SARAH HOUSE III, THE**

**1001 OLD TOMOKA RD  
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| A 010                    | <p>Continued From page 4</p> <p>The findings include:</p> <p>A record review for Resident #3's showed she had an 1823 health assessment dated . . . . . She was assessed as needing assistance with all activities of daily living except ambulation. Her record contained an order for a . . . . . vac dated . . . . ., authored by the primary care physician's office. Photographic evidence obtained.</p> <p>The primary care physician's office authored a note dated . . . . . which stated Resident #3 had a . . . . . vac in place. Another note authored . . . . . explained Resident #3 continued to use the . . . . . vac, and received assistance from home health three times a week. Photographic evidence obtained.</p> <p>On . . . . . at 2:21pm an interview was conducted with the . . . . . care nurse from Resident #3's home health agency. She confirmed the residents had a . . . . ., and the area was improving with the use of the . . . . . vac.</p> <p>A review of staff training revealed that in . . . . ., staff members from the facility received training in . . . . . vac procedures.</p> <p>On . . . . . at 1:15pm during an interview with Director of Operations, she stated Resident #3's son did not want Resident #3 to leave the facility, but did not want the . . . . . vac to be removed either.</p> <p>A clinician from Resident #3's primary care was interviewed on . . . . . at 5:35 PM. He explained that Resident #3 currently had a</p> | A 010               |                                                                                                                          |                          |

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| A 010                                                           | Continued From page 5<br><br>vac and the area was improving as a result of the<br>intervention.<br><br>CLASS III             | A 010                                                                                               |                                                                                                                          |                          |                                                                    |