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
	AL11943128	A. BUILDING: _____ B. WING _____	06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S HOME	718 W. WINTER PARK STREET ORLANDO, FL 32804

(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 A Complaint Investigation #2021007594 was conducted at St Mary's Home on , , and . The facility had a deficiency at the time of the survey.	A 000		
A 076 SS=J	59A-36.009 FAC ( ) (1) POLICIES AND PROCEDURES. (a) Each assisted living facility must have written policies and procedures that explain its implementation of state laws and rules relative to ( ). An assisted living facility may not require execution of a as a condition of admission or treatment. The assisted living facility must provide the following to each resident, or resident's representative, at the time of admission: 1. Form SCHS- , "Health Care Advance Directives - The Patient's Right to Decide," , , or with a copy of some other substantially similar document, which incorporates information regarding advance directives included in chapter 765, F.S. Form SCHS- is available from the Agency for Health Care Administration, 2727 Mahan Drive, Mail Stop 34, Tallahassee, FL 32308 or the agency's website at: http://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/HC_Advance_Directives/docs/adv_dir.pdf; and, 2. DH Form 1896, Florida Form, , 2004, which is hereby incorporated by reference. This form may be obtained by calling the Department of Health's toll free number 1(800)226-1911, extension 2780 or online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04005.	A 076		

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A 076	Continued From page 1 (b) There must be documentation in the resident's record indicating whether a DH Form 1896 has been executed. If a DH Form 1896 has been executed, a yellow copy of that document must be made a part of the resident's record. If the assisted living facility does not receive a copy of a resident's executed DH Form 1896, the assisted living facility must document in the resident's record that it has requested a copy. (c) The executed DH Form 1896 must be readily available to medical staff in the event of an emergency. (2) LICENSE REVOCATION. An assisted living facility's license is subject to revocation pursuant to section 408.815, F.S., if, as a condition of treatment or admission, the facility requires an individual to execute or waive DH Form 1896. (3) PROCEDURES. Pursuant to section 429.255, F.S., an assisted living facility must honor a properly executed DH Form 1896 as follows: (a) In the event a resident experiences or , staff trained in , , , ( ) or a health care provider present in the facility, may withhold (, and). (b) In the event a resident is receiving hospice services and experiences or , , facility staff must immediately contact hospice staff. The hospice procedures take precedence over those of the assisted living facility. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have written policies and procedures that explained its implementation of state laws and rules relative to Do Not	A 076		

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A 076	Continued From page 2 Orders ( ) and failed to perform , , ( ) on 1 of 1 sampled resident who did not have a and who , , (#1). Findings: Review of an Adverse Incident Report revealed that on at 8:59 p.m., the facility's administrator was conducting his nightly rounds when he found resident #1 in bed with her facing downward into the pillow. He attempted to arouse her, but she was unresponsive. He said he called 911 immediately. Review of a police report, dated , revealed documentation that indicated the fire department arrived on scene at /PM and pronounced the resident at approximately 9:13 p.m. on . An attempt to interview emergency medical service staff was unsuccessful. They would not interview without a subpoena. Review of resident #1's record revealed it did not contain any advance directives, including a . At 10:32 a.m. on , the administrator said the resident complained of difficulty breathing everyday but continued to smoke. He said phone with her health care provider were scheduled but the resident refused to participate in the calls. At 10:53 am on , staff A said he did not work on but he did on and said the resident did not complain of feeling ill. He said she ambulated independently, was a heavy smoker, always said she could not breathe but continued to smoke.	A 076		

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A 076	Continued From page 3 The administrator did not performed on resident #1 when he found her unresponsive because he said, "she was already blue; I just called 911; I just shake her, the body was already hard." He confirmed the resident did not have a . and said the facility's policy was that . would be performed if a resident did not have a . . He said he last saw the resident going outside at approximately 4 p.m. on , and when he checked on her at approximately 9 p.m. that same night, she was lying down in her bed; her . . . was positioned in the pillow, and it was blue. Review of the facility's undated policy revealed it did not explain the facility's implementation of State laws and rules relative to . . . such as procedures to address residents who receive hospice services. The administrator was trained in . per his personnel file. The resident was not receiving hospice services. Review of resident #1's contract revealed it contained a signed advance directive policy that was dated . The policy was inconsistent regarding how the facility would address occurrences in which residents had a and those in which the resident did not. For example, the policy indicated that if a resident did not have advance directives in place, life saving measures, including , would be performed. It also indicated if a resident had a . . , . would be withheld. And finally, it indicated that . would be performed on all residents. At 10:53 a.m. on . . . . . caregiver B said the facility's policy regarding was that if a resident did not have one, would be performed. If a resident did not have a	A 076		

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A 076	Continued From page 4 and , , the caregiver would perform under any circumstances when not receiving hospice. At 11:18 a.m. on resident #3 said that on the evening of , the administrator came into her room and said he believed resident #1 was then he asked her to come with him to the other resident's room. When she went to resident #1's room, the resident was laying down on her bed with her in the pillow. Resident #3 said she believed the resident was . Class I	A 076		