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
	AL11968816	A. BUILDING: _____ B. WING _____	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARAH HOUSE (THE)	30 FOREST CT ORMOND BEACH, FL 32174

(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 biennial relicensure survey was conducted on at Sarah House . Deficiencies were found at the time of the survey.	A 000		
A 036 SS=D	59A-36.007(10) CONTROL PROCEDURES (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of . (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on record review, staff interviews and observations the facility failed to provide services to reduce the risk of transmission of by not screening for COVID-19	A 036		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 036	Continued From page 1 symptoms upon entry to facility and staff not wearing masks. Failure to appropriately screen and use of personal protective equipment placed all 27 residents at risk for COVID-19. The findings include: Upon arrival to the facility on at 8:50 am, a sign was observed on the front door that stated the facility was on lock down due to COVID 19. The front door was locked, after ringing door bell a staff member came and opened the door. Upon entry to the facility the staff person did not perform screening for COVID-19. There were no forms available to fill out or thermometer to take temperatures. There were three staff members observed serving the residents breakfast in the dining room. 2 of the 3 staff were not wearing masks and were going in and out of the kitchen. During the entrance conference with the Administrator at 8:55 am on , she was asked why the facility was on lock down. She said they had one resident that had tested positive and had been for 10 days and had been retested this week and was negative, she said they were waiting for the second negative test. She had been in contact with health department and following their recommendations. The Administrator explained whoever answered the door was responsible for COVID screening upon entrance to the facility. She was asked how the screening process was conducted, she said temperature is taken and questions asked. When asked where the information was documented, she said we had a log at the front door however they hadn't been keeping it up since the facility was on lock down. She was asked who besides the staff were coming into the building, she said	A 036		

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A 036	Continued From page 2 just a few vendors, hospice, home health nurse and lab tech. She was asked if the vendors were being screened, she said we take their temperatures, however there was no record. She was asked who was screening the staff, she said they are supposed to take their temperatures when they come on duty, but she could not provide documentation of staff screening. She was asked if all staff were required to always wear masks, she said yes except when eating. She was informed there were two staff assisting with breakfast and going into the kitchen not wearing masks. She said she would need to have another in-service regarding control procedures and ensuring everyone entering facility be screened for COVID-19. The facility policy and procedure for visitation during COVID-19 stated the purpose was to ensure control, eliminate the possible introduction of COVID-19 to our communities and to inform and train all visitors and staff as well as support the safety of all residents, staff and all visitors. The mandated procedure stated they would be following all recommendations from CDC and incorporating them into the daily visiting routines of family, friends, essential caregivers and compassion care visitors. Screening was to include the following: temperature checks, questionnaire completion and sign in and sign out log, social distancing requirements. CDC recommendations titled "Interim Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus 2019 (COVID-19) Pandemic" dated instructs healthcare personnel to perform the following steps for routine control practice: Establish a process to identify anyone entering the facility, regardless of their	A 036		

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A 036	Continued From page 3 status, who has any of the following so that they can be properly managed: 1) a positive test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for or exclusion from work. Further, it recommends the following regarding source control: Source control refers to use of or well-fitting facemasks or cloth masks to cover a person's and to prevent spread of when they are breathing, talking, sneezing, or coughing. Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. Photographic evidence obtained. Class III	A 036		
A 162 SS=D	59A-36.015(3) FAC Records - Resident (3) RESIDENT RECORDS. Resident records must be maintained on the premises and include: (a) Resident demographic data as follows: 1. Name, 2. , 3. Race, 4. Date of birth, 5. Place of birth, if known, 6. Social security number, 7. Medicaid and/or Medicare number, or name of other health insurance , 8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case of an emergency; and, 9. Name, address, and telephone number of the health care provider and case manager, if	A 162		

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A 162	Continued From page 4 applicable. (b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C. (c) Any orders for medications, nursing services, therapeutic diets, , or other services to be provided, supervised, or implemented by the facility that require a health care provider's order. (d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable. (e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C. (f) A record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their recorded semi-annually. (g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract. (h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C. (i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C. (j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.	A 162		

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A 162	Continued From page 5 (k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S. (l) If the resident is an recipient, a copy of the Department of Children and Families form Alternate Care Certification for , ( ), CF-ES 1006, , which is hereby incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No =Ref-04004. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families. (m) Documentation of the of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable. (n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C. (o) The resident's , DH Form 1896, if applicable. (p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility: 1. A log listing the names of residents participating in this arrangement, 2. The resident demographic data required in this paragraph,	A 162		

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A 162	Continued From page 6 3. The health assessment described in rule 59A-36.006, F.A.C., 4. The resident's contract described in rule 59A-36.018, F.A.C.; and, 5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility. (q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility. (r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure Hospice documentation was located within the resident record for 1 of 2 resident records reviewed (Resident # 5). The findings included: During record review for Resident #5, there was a cover page observed on the outside of the chart that indicated she was on Hospice services with a phone number to call with any changes. There was no documentation in the record regarding Hospice services provided. An interview was conducted with the Administrator on at 3:45pm. She was	A 162		

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A 162	Continued From page 7 asked if Resident #5 was receiving Hospice services, she said "yes" since , of this year. When asked how the Hospice staff communicates with the facility, she said they sign in when they visit. She was asked where were the Hospice care plans, visit notes and physician orders, she said they don't leave them since they do everything in the computer. She has been told by Hospice staff that they will print them and bring to the facility, however they don't do that. She confirmed she would need to contact Hospiceto provide the records. Class III	A 162		