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|---|---|---|
| | AL11965661 | 04/25/2016 |
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SUMMARY STATEMENT OF DEFICIENCIES
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**0000 Initial Comments**

Complaint Investigation #2016003190 was conducted on , , and / . Spring Hills Lake Mary had deficiencies at the time of the visit.

**0025 Resident Care - Supervision**

Based on record review and interview, the facility failed to notify the residents' family or responsible party when there was a change in condition that required medical treatment for 5 of 11 sampled residents (#1, 3, 4, 8, 9 & 10).

Findings:

There was an outbreak of in Spring cottages a dedicated memory care unit within Spring Hills Lake Mary Assisted Living Facility that was reported on . However, on / at 11:29 AM the Director of resident Care indicated some of the residents had the ' as of . Record review revealed the following family members or responsible party were not notified on the outbreak or that their loved ones were being treated for a :

1. Review of resident #1's record revealed there was a telephone order dated for Clotimazole-Betamethason Cream 1-0.05% three times a day for ' for 14 days. It was documented in the record that a telephone order was received for 5% lotion to be applied from head to toe at night and wash off in the morning. This was an immediate (STAT) order for the diagnosis of . The record revealed that on , there was a referral to for itching. cream was ordered twice a day ( ) for 7 days, as long as the /itch was present. However, there was no documentation that the resident's family was contacted during this timeframe for this medical treatment.

2. Review of resident #3's record revealed a telephone order on from the resident's physician for one dose of Cream. A second telephone order was received on / / for 9 mg 1 time dose. Further record review revealed a note dated / that indicated there was a telephone order received from the resident's physicians for Cream for as a one-time dose. It was not until the third time that the resident received treatment for a that it was documented that the resident's family member or responsible party was notified ( ).

3. Record review for resident #4 revealed documentation in the record dated / from the hospice interdisciplinary plan of care revision: "symptom: agitation provoking factor ' ." Orders included dose pack for itch/ ' and Hydroroydine for itching. A / telephone order from

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the resident's physician for Cream for a ' was ordered as a one-time dose. There was no documentation that the resident's family or responsible party were notified of the resident's change in condition for a .

4. Review of resident #8's progress note, dated , found a new order for Cream for " as a one-time dose. A note dated read, "Onsite Assessment Impression: ' is an 8 on a scale of one to ten. The patient has had ' for 1 month. The ' has been treated with nothing. Plan: Isolation until after treatment is given, 3 mg. (milligrams), 4 tabs PO (orally) x 1 dose, 10 mg. 1 tab PO x 30 days, 0.1% cream x 2 weeks, prn (as needed) itch; wash all clothing and bedding in hot water. There was no documentation that the family member or responsible party was notified of the impression of presence of .

5. Review of resident #9's record revealed that on , an order for Cream was received from the resident's physician. The cream was to be applied to the body for a as a one-time dose. On / , the resident complained of itchiness and a was seen on the resident's trunk. Per the record, "Family and DR (physician) notified." The physician ordered 0.1% cream to be applied to the body for the ' for 14 days. On , a was seen all over the resident's body and cream continued to be used. On at 9:06 (no time of day noted) observed a closed scab on resident's right arm. On / / at 8:52 (no time of day noted), a telephone order from the resident's physician ordered 10 mg. 1 tablet by mouth in the evening for ' for 30 days to be given. On / / at 6:14 PM, the resident sat in the common area, socializing with other residents. On / / , the resident was seen scratching her back and torso area. The record reflected that the ' to the back and torso remained unchanged. The resident increased scratching on that day.

Interview with the resident's family member on / at 3 PM revealed that she was not notified on the on her mother's body until she went to visit on / / and questioned what that was all over her mother's body.

6. Resident #10's record revealed a new order on from the physician for Cream for " as a one-time dose. A note read, "Onsite Assessment Plan: Isolation until after treatment is given 3 mg., 4 tabs PO x 1 dose, ( ) 10 mg 1-tab PO x 30 days, 0.1% cream x 2 weeks, prn itch; wash all clothing and bedding in hot water." There was no documentation that the resident's family or responsible party was notified.

Interview with the Director of Resident Care on / at 11:29 AM who was asked if the residents'

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families were notified. He said "Yes, they were." However, there was no documented evidence to support that response. Review of the resident's record revealed the families were not notified when the first started and the first treatments were given.

Class III

**0030 Resident Care - Rights & Facility Procedures**

Based on observation, record review and interview, the facility failed to provide health care related to communicable and consistent with established and recognized standards in the community, failed to follow their established policy and procedures for control, and failed to contact the Health Department in a timely manner and follow Health Department recommendations for 9 of 11 sampled residents (#1, 2, 3, 4, 6, 7, 8, 9 & 10).
Findings:
The Agency for Health Care Administration had contact with the local Health Department regarding an outbreak of in the Memory Care unit of the facility. The Health Department indicated that the facility had not been forth coming with information and was not with the Health Department.
A tour of the Memory Care unit, Spring Cottages, was conducted on at approximately 9:15 AM. The residents sat in the common areas interacting with each other. Several residents were observed scratching themselves. One alert resident #5 was asked if she was itching and she stated "Yes", her legs were itching. Red marks were seen on her legs. Upon entering Spring Cottages, there were no signs visible to advise visitors of the outbreak of the " " on the unit. No resident was seen on contact isolation.
During an interview with the Director of Resident Care on at 11:29 AM revealed that he was not aware what was actually going on in the Spring Cottages. He referred to the outbreak as a However, he indicated that residents had the as far back as He said Resident #2 had a skin scraping which came back positive for on / . The facility did not acknowledge that they had a problem with They referred to the problem as a

1. Resident #1's record revealed she had a that dated back to 2015. The resident's progress notes reflected the following:
/ , a telephone order (TO) from the resident's physician was received for Clotimazole- Cream 1-0.05%, a anti-fungal cream, to be applied three times a day for for 14 days.
/ , a TO from the resident's physician was received for 5% Cream to be applied to the toe at night and wash off in the morning STAT (immediately) for diagnosis of .
/ at 3:30 PM, a TO from the resident's physician was received for 25 mg. (milligrams) twice a day ( ) as needed for itching.

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/ , a consultation and cream x 7 days for itching was ordered.
/ , an "Onsite Assessment No Diagnosis Treatment prescribed: 3 mg. 4 tabs PO (orally) 10 mg. PO daily x 30 days, cream - apply to arms, legs & trunk x 4 weeks Wash all clothing and bedding in hot water."
, a TO from the resident's physician was received to refill ( ) , cream 0.05% to arms, legs and trunk .
, the onsite assessment was scored a 2 out of 10. The dermatologist indicated the resident exhibited the for 2 months. The was treated with orally. This treatment improved the . The impression was " , Follow up in 6 months. to trunk is improving- monitor for changes keep skin clean and dry. f/u as needed."
/ , a prescription was received for Cream 8% to be applied to the neck down times 8 hours: Wash in AM repeat in 1 week 2 refills. A diagnosis was not documented.
, a report indicated the resident was seen in follow-up for extreme itching of the body. The dermatologist indicated the resident had been treated numerous times for . The dermatologist wrote, "Pramosone previously prescribed has never been given, please add to regimen."
/ , a progress note read, " cream applied, itching did not decrease."

2. Resident #2's record on / / indicated a of incognito listed as the most likely diagnosis.
, a assessment read, "Impression: , is a 4 out of a scale of one to 10, where 10 is the worst. Patient has had for 1 week. has been treated with nothing. Plan: Isolation until after treatment is given. 3 mg, 4 tabs PO x 1 dose, 10 mg 1 tab PO x 30 days 0.1% cream x 2 weeks' prn itch, wash all clothing and bedding in hot water."
/ , was given for .
, a assessment read, "Impression: . is a 4 of 10 Patient has had for 2 months. has been treated with pill and cream. This treatment made the better. Follow up in 6 months.
, an in-house "Skin Observation Tool" report read, "No skin observed at this time."
/ , cream was ordered to be applied to the body one time.

3. Resident #9's progress notes reflected the following:
, Cream was ordered to be applied to the body one time.
, the resident complained of itch and a was seen on the resident's trunk. The physician ordered 0.1% cream to be applied for for 14 days.
, the resident had a closed scabbed right arm.
/ , a TO was received for 10 mg. by mouth in the evening for for 30 days.
/ , the resident sat in the common area, socializing with other residents.
/ , the resident's body remained unchanged.

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, the resident was observed scratching the back and torso. The on the back and torso remained unchanged. The resident increased scratching that shift.
, a TO was received for cream to be applied every 4 hours as needed for body .
/ , the resident continued to complain of itchiness.
/ , the was seen on the majority of the resident's body.
/ , cream was applied to the body three times a day.
/ , an in-house "Skin Observation Tool" report reflected "Scabbed areas to resident body, no skin ."
/ , cream was applied to the body once only.
/ , in-house "Skin Observation Tool" report read, "Observed dry/healing post on resident's arm and neck. Continue cream 3 times daily until resolved."
/ , continues to improve slowly.

4. Resident #3's progress notes reflected the following:
/ / , a TO was received for 9 mg. 1 time dose
/ , a TO was received for Cream for , one time dose.
/ , an onsite assessment impression read, " : is a 7 of 10 Patient has had for 1 week. has been treated with nothing follow up in 1 month. Plan: isolation until after treatment is given, 3 mg. 4 tabs PO x 1 dose, 10 mg. 1 tab PO x 30 days. 0.1% cream x 2 weeks, PRN for itch, wash all clothing and bedding in hot water.
/ / , a TO was received for cream for x 14 days and 10 mg. daily x 30 days.

5. Resident #4's progress notes indicated the following:
/ , the hospice wrote an "Interdisciplinary Plan of Care Revision Symptom" of agitation with a provoking factor of and . Orders included dose pack for itch/ and Hydroroxydine for itchiness.
/ , a TO was received for Cream for a , one time dose.
, an onsite assessment read, "Plan isolation until after treatment is given 3 mg. 4 tabs PO x 1 dose, 10 mg. PO x 30 days, and 0.1% cream x 2 weeks PRN for itch; wash all clothing and bedding in hot water."
, an onsite assessment impression read, " , is a 4 out of 10, where ten is the worst. The patient (resident) has had for 2 months. has been treated with and cream. This has made the better. Follow up in 1 month."
, an in-house "Skin observation Tool" report read, "No skin observed at this time."
, a TO was received for Cream for , one time dose.

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6. Resident #6's progress notes reelected the following:
/ , a new order was received for Cream for , one time dose for , treatment.
, a TO was received for Cream for , one time dose.
, an onsite assessment impression read, " / is a 6 out of 10, where ten is the worst. The patient has had ' for 1 week. has been treated with Nothing. Follow -up in 1 month. Plan: Isolation until after treatment is given, 3 mg,4 tabs PO x 1 dose, 10 mg 1 tab PO x 30 days. 0.1%cream x 2 weeks, prn itch; was all clothing and bedding in hot water."
, a TO was received for cream for itching.
, a assessment impression read, " , is a 2 out of 10, where ten is the worst. The patient has had ' for 2 months. has been treated with and cream. This has made the better."
, cream was applied to the resident's body, .

7. Resident #7's progress notes revealed the following:
, a new order was received for Cream for / one time dose.
, a small closed scab was seen on the resident's right arm.
, a assessment plan read, " 3 mg. 4 tabs PO x 1 dose, 10 mg. PO x 30 days, and 0.1% cream x 2 weeks, PRN itch."
, a assessment impression read, " , is a 3 out of 10, where 10 is the worst. The patient has had ' for 2 months. has been treated with and "
, cream was applied to the resident's body as ordered.
, an in-house "Skin Observation Tool" report read, "Observed multiple , areas to resident lower extremities and closed scabs to arms. "An , is a spot of ." (Wikipedia.org).

8. Resident #8' progress notes reflected the following:
, a new order was received for Cream for /, , , one time dose.
, a assessment impression read, " , is an 8 of out 10, where 10 is the worst. The patient has had ' for 1 month. has been treated with nothing. Plan: Isolation until after treatment is given, 3 mg., 4 tabs PO x 1 dose, 10 mg 1 tab PO x 30 days. 0.1% cream x 2 weeks, PRN itch, wash all clothing and bedding in hot water."
/ , a assessment impression read, " is a 3 out of 10, where ten is the worst. The patient has had ' for 2 months. has been treated pill. this has made the better."
/ , an in-house "Skin Observation Tool" report read, "No skin , observed at this time."

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, cream was applied to the resident's body as ordered.
, an in-house "Skin Observation Tool" report read, "Observed areas to resident lower extremities and closed scabs to arms."

9. Resident #10's progress notes reflected the following:
, a new order was received for Cream for /, , , one time dose.
, a assessment plan read, "Isolation until after treatment is given 3 mg. 4 tabs PO x 1 dose, 10 mg. PO x 30 days, 0.1% cream x 2 weeks, PRN itch; wash all clothing and bedding in hot water."
/ , an in-house "Skin Observation Tool" report read, "Light observed to resident's trunk. New orders Ivermectrin 3 mg. PO one time."
/ , a assessment impression read, " is 5 out of 10, where 10 is the worst. The patient has had for 3 months. has been treated with pill. This has made the same. Follow-up 1 month. Plan: Established problem, worsening (located on trunk) 3 mg. 4 tabs PO daily x 1 dose (repeat dose)."
, a TO was received for cream to be applied to the body one time only.

Review of the facility's Control Log revealed all but 3 of the 11 sampled residents' date of onset of the was . However, this was not documented in the residents' progress notes. The log listed six of the ten sampled residents as being resolved as of / (#2, #3, #4, #7, #8 and #10).

The facility's Control Monitoring Policy read, "Should reportable conditions be detected during monitoring surveillance, the Director of Resident Care will contact the appropriate health authorities and will cooperate with appropriate investigation and reporting activities.
1. Reportable conditions shall be 10% of the total population and/or any percentage of the staff or resident population which is out of the ordinary for the community.
2. Family members and the general public will be informed of any outbreak by way of posting notice in a conspicuous place in the community, and/or call the family member directly."
The facility had several Control policies, but the facility staff did not follow any of them, including: Control - Reporting Communicable , Outbreak Management and Control/Isolation.

On at 10 :53 AM, staff A (caregiver) was asked about the in the Memory Care unit, Spring Cottages. She stated she started seeing spots on the residents and cream was being applied. They didn't know what it was until the dermatologist came in to assess the residents. She was asked if she had the and she stated she started to itch. She said she noticed a on her left side and reported it to her supervisor. "I was given a cream and was told to leave it on for 12 hours." She said more than two weeks later, she broke out in a . Last week her supervisor gave her another cream

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and pills (30 pills) she is still taking the pills. She explained you have to take the pills for 30 days. Currently she stated that she did not have a [illegible]. She stated that she has marks left from where the [illegible] was on the left side of her abdomen because of the scratching. She did not know the names of any of the medications or creams she is taking. She was asked what she was told about the [illegible] and stated that no one told her or her co-worker to her knowledge. She stated none of her family members had developed the [illegible] to date. She stated that this was not the first time this has happened in this community. She stated, "A couple of years back, the facility told them what it was and how to prevent it. I just knew to wash sheets, hot dryer, etc. I was not told anything this time. I assumed it might be what it was before. I think it's pretty much subsided." Staff A was asked if she worked in the Assisted Living Facility (ALF) and stated, "I work on the Assisted Living side on Thursdays." She was asked if she had the [illegible] when she worked on the ALF side and stated "Yes." She added that she did not know if the nurses including the Director of Resident Care checked the residents in the ALF for the [illegible]. She stated that a couple of other co-workers had the [illegible]; they work on different shifts. I am not aware what they were told it was either." She was asked: Do you know who the original case was and stated "Resident #1. I think she had the [illegible] before [illegible] (2015) after a hospital stay. The facility treated the [illegible], her son took her to an outside dermatologist. He did not tell us what was wrong with her. She came from the ALF side, but did not have the [illegible] when she came to Memory Care. She [illegible] in 2015."

On [illegible] / [illegible], it was reported by the Administrator and The Director of resident Care that staff A reported being itchy, was given cream again, and told to stay home.

During an interview with staff B on [illegible] at 11 AM, she started to work at the facility in [illegible] 2016. She stated that she did not get the [illegible], but was treated. She said she did not know what it was but it was a cream. She said she applied it after a shower and left it for 8-10 hours, one time only. She said she was not directed to apply the cream more than once. Staff B stated that she usually works in the Memory Care unit and will work in the ALF one day this month, [illegible] 2016. She said the last time she worked in the ALF was approximately a month and half ago. "I did not notice any rashes when I first started. Residents complain of itchiness. It starts like a blemish, then spreads. No scabs that I have seen. When she was asked if the facility told her what it was, she replied, "No, I couldn't tell you. I just know it's a [illegible] and it's itchy." She was asked if anyone has it now, and said, "I know some are itching. About 1 and a 1/2 weeks ago, we applied the same cream that I used to all of the residents. I applied it when toileting them. I stripped them of all their clothing and applied it generously. The next shift, 8-10 hours later, took it off."

On [illegible] at approximately 1:21 PM, registered nurse (RN) C stated she did not get the full [illegible], just a few spots. She said, "They gave us a cream. I used it 2 days. They said to do it 3 times. I put it on and 8-12 hours later, washed it off. The dermatologist said they did not know what it was. I used the cream

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and the spots went away. No worker's compensation was offered. No observation was offered. I don't remember if they told me, but I knew we could get it from the residents. I was concerned about bringing it home. When I got home, I showered and changed clothes." When she was asked if she did her laundry, she said, "I did them separate. I always wash my work clothes separately. No one at home got the . I know a resident said they were itchy. I have no idea when I first saw spots. I think resident #9 was the first and the most irritated by it. There may have been scabs from so much scratching." When RN C was asked if any other residents with scabs she stated "No". She has not observed any residents currently still itching. When she was asked if she was told what the was, she stated, "In my mind, I have an idea of what it is."

On at 11:29 AM, Director of Resident Care D stated the onset of the was . The director said multiple residents had a skin irritation of an unknown origin. We called doctors and the made families aware. We brought in onsite as an additional resource. Nothing was definitively identified. No one told us what it was. We treated it as . A provider provided a treatment plan. The County Health Department was notified of the findings, " Incognito". The director was asked if the residents with the were until after they underwent treatment, and to wash all affected residents' clothing and bedding in hot water. The director stated he did not have a way to do that. He stated, "We did as much as we could to prevent spreading, fumigation, cleaning." The director was asked about the reports from onsite and stated that they did not automatically send the reports. He was asked if he called to request the reports and stated he did not call. He was informed that there were reports dated in the residents' records. When asked about what the dermatologist told the staff, and if the ALF residents and staff were affected, he said, "All of the staff we were treated for a skin ." He further stated the ALF was not affected, even though the facility has staff that work in the Memory Care unit and the ALF. According to the director, there skin sweeps were not done when the facility became aware there was a in the Memory Care unit, and some of the staff who worked in the Memory Care and the ALF had developed the . The director was asked when the reports stated 2-3 months for duration, why this was not reflected in their control log but he did not have an explanation. He said, "We checked records; the started in 2015, but when we saw it popping up everywhere, we started tracking it on ."

On at 3 PM, staff E stated she has been itching since around the middle of 2016. She said the facility gave her the cream and offered her the pills maybe a week ago. She said she stopped taking the medication a couple of days ago. She said, "They did not tell me what we were being treated for, and I didn't question why I was taking it. They told me about washing laundry. I don't have any family at home." Staff E stated, "I work Thursdays and every other weekend on the ALF side. I do meds and rotate between the 2 units. The last time I was in the Memory Care unit was a Wednesday last month ( 2016). I haven't seen anyone in the ALF side itching. I noticed the resident's skin color

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being red, with bumps. Maybe around the New Year or Thanksgiving. I did not notice anything in the summer". I have not seen any assessments. Resident (#1) had it a long time, really bad. She went to the hospital and they said it wasn't . We washed her clothes separately and kept them separate. We have not had any in-services on Control since the outbreak."

During a telephone interview with staff F on at 12:50 PM, she stated she got the 3 weeks ago. The nursing staff gave her cream to treat it, but she did not receive any pills. She said none of her family members got the . She said she has not worked in the ALF in the past 60 day, and has not heard about anyone in the ALF itching. Staff F stated none of the residents are still itching. According to staff F, an informal in-service about control was conducted about 3 weeks ago but there were no specifics that she remembered. When asked if she was told what the was, she stated, "The Director of Resident Care told me it was ."

Staff G (Recreation Assistant), H (Housekeeping Supervisor), I (Housekeeping), J (Caregiver), K (Caregiver), L (Caregiver) and M (Licensed Practical Nurse) who work both in the Memory Care unit and the ALF and those who only worked in the ALF. They all stated they were offered the cream. Some said they used the cream and some stated they did not. They were told that it was a in the Spring Cottages (memory care unit). There was no information about the specifics of what type of or how to wash their clothes and bedding as to not their family members.

Based on documentation provided by the local Health Department, the facility was contacted by the Health Department on by email and asked to complete the Florida Health " Like Illness Contact Line List Form: Patients." A repeat request was made on / . When asked about the lack of communication with the Health Department and slow response to provide requested information they didn't have a response.
The Health Department visited the facility on / and discussed outbreak control guidance. Copies of the Centers for Control (CDC) guidance were provided to the facility. The information was given to The director of Resident Care which includes signs and symptoms, control and treatment, complications, surveillance and communications.

On / , The Health Department emailed the facility and recommended methods for controlling the outbreak. The Health Department told the facility they would follow-up with the facility on a weekly basis.

On at 10 AM, representatives of the Health Department reported that they did not receive cooperation or responses from the facility concerning the outbreak.

A review of the facility in-service logs reflected they did not provide training that specifically addressed topics relative to persons infested with , including prevention, detection, treatment, containment,

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11965661 | 04/25/2016 |
| NAME OF PROVIDER OR SUPPLIER<br>**SPRING HILLS LAKE MARY** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**3655 W. LAKE MARY BLVD.**<br>**LAKE MARY, FL 32746** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

and reporting.

An in-service on Hand Hygiene was completed electronically by 52 staff members between , 2015 and 2016. There was a handwritten sign-in sheet from 2015 (no specific day), for an in-service called, "Hygiene, Cleanliness, Control upon returning from Dining, Mop & Sweep Floors Experience." Hours were not provided for review for the in-service. The Director of Resident Care (DRC) presented the in-service which was attended by 11 staff members. On , 2016, an in-service called "Private Caregivers/cleaning up Control" was presented by DRC. Hours and agenda were not provided for review. Ten staff members attended the in-service. No other in-services were provided for review.

There were three (#2, #7, #9) residents currently having symptoms of the on .

A tour was taken in the company of the Director of Resident Care of the Assisted Living unit to observe the residents and staff to see if there were any signs or symptoms of the . The Director of Resident Care stated there were no residents with rashes.

During a revisit to the facility on at approximately 10 AM, Director of resident Care and the Administrator were informed Agency staff and Representatives from the local Health Department that staff A complained of itching and she was instructed to remain at home. There were also three residents (#7, #3 and #9) in Spring Cottages who continued to have the . The facility was informed at that time they need to start from the beginning and follow all the recommendations from the local Health Department. They needed to post a sign so that all visitors, family members and staff would be aware of the as they entered the unit. They were given instructions in detail by the representatives of the local Health Department how to clean and the mite as it was described by the representatives from the Health Department. The administrator and the Director of Resident Care agreed to start from the beginning and follow the recommendations from the Health Department and their policy as it relates to control and outbreaks in the community.

Class II

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Spring Hills Lake Mary
3655 W. Lake Mary Blvd.
Lake Mary, FL 32746
Nick Lynn, Administrator

Dear Mr. Lynn:

This letter reports the findings of a complaint investigation #2016003190 survey conducted on , , and by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) **by** / .

The inspection resulted in findings of non-compliance in the following areas:

1) A - 0030 - Resident Care - Rights & Facility Procedures Class II
The facility failed to provide adequate and appropriate health care consistent with established and recognized standards in the community and failed to follow their established policy and procedures for control, and failed to contact the Health Department in a timely manner and follow the Health Department recommendations.

Directed Corrective Actions:
1. All direct care staff must be re-trained on control procedures, especially concerning containing outbreaks of /rashes that a spread through skin to skin contact. This training must be conducted by a representative of the Department of Health or their approved provider and should include education about contacting and coordinating with the Department of Heath during outbreaks. A copy of the sign in sheet must be available for review upon request by the Agency. This must be conducted **by** / .

2. The facility needs to update your policy and procedures so that the most current guidelines from the Health Department are included. The policy and procedure should also include that family members and representatives should always be contacted concerning the resident's health. An in-service will need to be conducted to familiarize your staff with the updated policy and procedure and to discuss any concerns and any questions the staff may have. A copy of the updated policy and procedure and the sign ins sheet must be available for review upon request by the Agency. This must be conducted **by** .

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com

Spring Hills Lake Mary
, 2016

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact . Lorraine Henry, ALF Unit Orlando, at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be

D7JR

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Orlando Field Office
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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Spring Hills Lake Mary
3655 W. Lake Mary Blvd.
Lake Mary, FL 32746

**RE: CCR #2016003190**

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

XG90

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
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