STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968816	09/09/2016
NAME OF PROVIDER OR SUPPLIER **SARAH HOUSE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **30 FOREST CT** **ORMOND BEACH, FL 32174**	

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

0000 Initial Comments

On a complaint survey (CCR #2016006710) was conducted at Sarah House (License #12649). Deficient practice was identified during the survey.

0078 Staffing Standards - Staff

Based on a review of resident records, and interview with staff, the facility failed to report unusual observations to the resident's health care provider when the resident experienced a significant event or change in condition, for 2 of 2 sampled residents reviewed for (Resident #34 and #26).

The findings included:

A record review for Resident #44 found an AHCA form 1823 (resident health assessment) dated which noted a diagnosis of . He required general oversight for his whereabouts and well-being on a weekly basis. His wife was his designated Power of Attorney (POA).

A letter to Resident #44's POA (dated , and authored by the Administrator) referenced this resident's behaviors over recent weeks. A request for a evaluation had been made by the facility to control Resident #44's inappropriate advances toward another resident. A 45-day notice was issued to Resident #44 in the event they could not get the situation under control. Additional notes, dating back to were located in the record, and referenced Resident #44's inappropriate to a female resident.

An interview was conducted with the Administrator at 2:43 pm on . When asked about the nature of the inappropriate advances referenced in Resident #44's record, she explained he was a "ladies' man." He had his eye on a female resident (Resident #34). She explained he would follow Resident #34 and go into her . Staff would redirect him out of the this occurred. The Administrator spoke to the resident's POA about a evaluation, which was agreed to. Last week, Resident #44 and Resident #34 were doing more than just holding hands. Resident #44 went into Resident #34's , and was on top of her. He had his pants on, and was trying to take them down. An aide found the two, and Resident #34 told thanked the aide for coming in. The Administrator said she requested a written statement from the aid who discovered the incident, Employee F, caregiver.

A record review for Resident #34 found an AHCA 1823 (resident health assessment) dated

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which noted a diagnosis of [redacted]. Resident #34 was alert and oriented to herself only, very [redacted], and agitated at times. She required assistance with self-care tasks, and daily oversight for her whereabouts and well-being.

A note dated [redacted], and authored by the facility's Community Director indicated she spoke with Resident #34's POA about a male resident "going a little further than the previous time" with Resident #34. The narrative explained that both residents were clothed, and that he was found "on top of her." As a result, the facility would issue a 45-day notice to the (male) resident.

A review of facility records revealed a hand-written statement authored on [redacted] by Employee F. She noted she found Resident #44 in Resident #34's [redacted], on top of her. He was trying to remove her underpants. Employee F asked Resident #44 him to leave the [redacted]. Resident #34 was shaking and crying, and stated she was glad Employee F was there. Resident #44 was hugged and reassured she would be okay.
The incident report completed by the facility on Resident #34 on [redacted] indicated her family had been notified about the incident about steps needed to stop the behaviors. The section indicating notification of Resident #34 ' s health care provider was left blank.

An interview was conducted with the Administrator at 2:57 pm on [redacted]. She was asked what was done in response to the incident. She produced an in-service signature sheet and said she had trained all staff in [redacted] on [redacted]. The agenda and training content was reviewed. Under the [redacted] section of the pamphlet, one of the examples included forcing an elder to undress as [redacted] elder [redacted].

In a second interview at 3:40 pm, the Administrator stated family was notified in the suspected event of [redacted], and an investigation completed and documented. She confirmed the removal of an elder ' s clothing was what she trained her staff on regarding [redacted]. She acknowledged that she therefore should notified Resident #34's physician following the occurrence. She acknowledged that Resident #34 had suffered some emotional harm from the situation, as evidenced by her shaking and crying. She agreed Resident 34 may have benefited from some professional [redacted] support.

2. In an interview with the Administrator at 3:40 pm on [redacted], she stated she once received a report that an employee slapped a resident in the face. She stated the incident was investigated, and the employee terminated, as the incident was believed to have occurred.

Review of the facility records for this incident found a written statement dated [redacted] by Employee G, a caregiver, that she saw Employee X, a caregiver, slap Resident #26 in the face. She noted this

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occurred on , and that the blow was forceful enough that the resident's glasses moved across his face. Employee X was overheard threatening to call Resident #26's wife, and he then said he was sorry.

A record review for Resident #26 found he had a family member who was his designated Power of Attorney (POA). His AHCA form 1823 (Resident Health Assessment) dated and signed by the physician noted Resident #26 had a diagnosis of . He was independent with completion of activities of daily living, and required the assistance of his POA for handling personal affairs

A note authored by the Administrator and dated / indicated the the Community Directors were notified of the allegation involving Resident #26 and Employee X on . She noted Resident #26 was unable to participate in the investigation due to his . Employee X had been suspended pending outcome of the investigation. Department of Children and Families workers were noted to be called for guidance, but there was still no return call. On , 3 days following the observed incident, Resident #26's POA was notified. There was no documentation that Department of Children and Families hotline was notified, as required.

A letter to Employee X dated was provided by the facility. It stated she was being terminated as a result of the investigation.

Class III

0160 Records - Facility

Based on observations, facility record review, and interview with staff, the facility failed to maintain an up-to-date admission and discharge log listing the names of all residents and each resident's:

1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a pressure ; and

2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged for 4 sampled residents (Residents #6, #50, #51 and #52) who were not noted on the log.

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The findings include:

Review of the facility admission and discharge log revealed there were 30 residents residing in the building at the time of survey.

A 100% resident wellness observation was conducted on at 10:25 am with the Community Director using the admission/discharge log to mark off resident names as they were observed. During the wellness check, it was discovered that Resident #6 was still listed on the roster as an active resident. The Community Director confirmed at this time she no longer resided in the facility. Residents #50, #51 and #52 were observed in the facility; however, they were not listed on the current admission/discharge log.

An interview with the administrator at 11:00 am on confirmed the admission/discharge log was not up to date to include Resident #6's discharge, and the admissions of Residents #50, #51 and #52, as required.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on a review of resident records, and interview with staff, the facility failed to file an adverse incident report, or to report to the Department of Children and Families as required under Chapter 415 for 2 of 2 sampled residents reviewed for (Resident #34 and #26).

The findings included:

1. A record review for Resident #44 found an AHCA form 1823 (resident health assessment) dated // which noted a diagnosis of . He required general oversight for his whereabouts and well-being on a weekly basis. His wife was his designated Power of Attorney (POA).

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A letter to Resident #44's POA (dated / , and authored by the Administrator) referenced this resident's behaviors over recent weeks. A request for a evaluation had been made by the facility to control Resident #44's inappropriate advances toward another resident. A 45-day notice was issued to Resident #44 in the event they could not get the situation under control. Additional notes, dating back to / were located in the record, and referenced Resident #44's inappropriate to a female resident.

An interview was conducted with the Administrator at 2:43 pm on . When asked about the nature of the inappropriate advances referenced in Resident #44 ' s record, she explained he was a "ladies' man." He had his eye on a female resident (Resident #34). She explained he would follow Resident #34 and go into her . Staff would redirect him out of the this occurred. The Administrator spoke to the resident's POA about a evaluation, which was agreed to. Last week, Resident #44 and Resident #34 were doing more than just holding hands. Resident #44 went into Resident #34's , and was on top of her. He had his pants on, and was trying to take them down. An aide found the two, and Resident #34 told thanked the aide for coming in. The Administrator said she requested a written statement from the aid who discovered the incident, Employee F, caregiver.

A record review for Resident #34 found an AHCA 1823 (resident health assessment) dated which noted a diagnosis of . Resident #34 was alert and oriented to herself only, very ', and agitated at times. She required assistance with self-care tasks, and daily oversight for her whereabouts and well-being.

A note dated , and authored by the facility's Community Director indicated she spoke with Resident #34's POA about a male resident "going a little further than the previous time " with Resident #34. The narrative explained that both residents were clothed, and that he was found "on top of her." As a result, the facility would issue a 45-day notice to the (male) resident.

A review of facility records revealed a hand-written statement authored on by Employee F. She noted she found Resident #44 in Resident #34's , on top of her. He was trying to remove her underpants. Employee F asked Resident #44 him to leave the . Resident #34 was shaking and crying, and stated she was glad Employee F was there. Resident #44 was hugged and reassured she would be okay.

The incident report completed by the facility on Resident #34 on indicated her family had been notified about the incident about steps needed to stop the behaviors. The section indicating notification of Resident #34's health care provider was left blank.

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An interview was conducted with the Administrator at 2:57 pm on . She was asked what was done in response to the incident. She produced an in-service signature sheet and said she had trained all staff in on . The agenda and training content was reviewed. Under the section of the pamphlet, one of the examples included forcing an elder to undress as elder .

In a second interview at 3:40 pm, the administrator stated family was notified in the suspected event of , and an investigation completed and documented. She confirmed the removal of an elder's clothing was what she trained her staff on regarding . She acknowledged that she therefore should notified Resident #34's physician following the occurrence. She acknowledged that Resident #34 had suffered some emotional harm from the situation, as evidenced by her shaking and crying. She agreed Resident 34 may have benefited from some professional support.

2. In an interview with the Administrator at 3:40 pm on , she stated she once received a report that an employee slapped a resident in the face. She stated the incident was investigated, and the employee terminated, as the incident was believed to have occurred.

Review of the facility records for this incident found a written statement dated by Employee G, a caregiver, that she saw Employee X, a caregiver, slap Resident #26 in the face. She noted this occurred on , and that the blow was forceful enough that the resident's glasses moved across his face. Employee X was overheard threatening to call Resident #26's wife, and he then said he was sorry.

A record review for Resident #26 found he had a family member who was his designated Power of Attorney (POA). His AHCA form 1823 (Resident Health Assessment) dated and signed by the physician noted Resident #26 had a diagnosis of . He was independent with completion of activities of daily living, and required the assistance of his POA for handling personal affairs

A note authored by the Administrator and dated indicated the the Community Directors were notified of the allegation involving Resident #26 and Employee X on . She noted Resident #26 was unable to participate in the investigation due to his . Employee X had been suspended pending outcome of the investigation. Department of Children and Families workers were noted to be called for guidance, but there was still no return call. On , 3 days following the observed incident, Resident #26's POA was notified. There was no documentation that Department of Children and Families hotline was notified, as required.

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A letter to Employee X dated was provided by the facility. It stated she was being terminated as a result of the investigation.

Class III

Z816 Backaround Screenina-Compliance Attestation

Based on a review of employee files, and interview with staff, the facility failed to re-screen 1 of 3 sampled employees reviewed for Level 2 background clearance prior to hire (Employee C) and after a break in service from a position that required level 2 screening for more than 90 days.

The findings included:

A personnel file review for Employee C found she was hired as a Caregiver; however, her personnel file contained no actual hire date. Review of the application found Employee C was working at a fast-food restaurant when she applied for the Caregiver position at the facility. She indicated she started the restaurant job on / /, and was still employed there part-time. The application showed Employee C last worked as a Certified Nursing Assistant and caretaker from / / to / /. Further review of the file found Employee C had a Level 2 background screening which noted an eligibility date of / /. There was no re-screening performed for Employee C after hire by the facility, which was after / /.

An interview was conducted with the Administrator on at 4:30 pm. She reviewed Employee C's personnel file, and explained she did not know a new level 2 was required following more than a 90 day break in employment. She confirmed a new background screening should have been performed for Employee C prior to hire.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
The Sarah House
30 Forest Court
Ormond Beach, FL 32174

RE: CCR #2016006710

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on 2016 by representatives 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 22, 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 surveyors. Should you have any questions please call this office at -4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

LL/JM/sm
Enclosure
XG90

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