STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968816	03/01/2017
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

An unannounced biennial licensure survey was conducted at Sarah House (License #12649) on , 2017.

Sarah House had deficiencies found at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and staff interview, the facility failed to obtain accurate and complete AHCA 1823's (used for resident health assessment) for 2 of 2 sampled residents. (Resident #13 and #10)

The findings include:

1. Record review for Resident #13 found he was admitted to the facility on . Record review of the most recent AHCA 1823 based on a exam found "Needs Medication Administration" was checked, and the square next to "Needs Assistance with Self Administration of Medication" was circled, making it unclear which entry was correct.

The Administrator was shown the AHCA 1823 on at 3:05 PM confirmed the AHCA 1823 was the most recent and obtained when the resident was sent out to the hospital due to a and hip .

2. Record review for Resident #10 revealed she was admitted on . Her diagnosis included: , , , and D deficiency. Review of the 1823 from admission revealed she was alert with . She was ambulatory with walker and independent with dressing, eating, , toileting and stand by assist for bathing. Also stated needed precautions, had mild , and needed assistance with self administration of medications.

On , it was documented she returned from a hospital stay for -intestianl . Review of the Health Assessment dated was found incomplete, since the physician did not document (left blank) the type of assistance required for medications.

On Resident #10 returned from the hospital after treatment for right hip . Review of the 1823 dated revealed the resident required skilled services, total care, and administration of medications (which required a licensed nurse).The physician documented on the signature page, Resident #10 required medication administration.

In an interview with the administrator on at 3:15 PM, the contents of the 1823 were confirmed.

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She stated that the 1823 was inaccurate and should have been corrected. Resident #10 did not require medication administration.

Class III

0010 Admissions - Continued Residency

Based on record review, observations and staff interview the facility administrator failed to determine the appropriateness for admission for resident (Resident #10) requiring higher level of care for 1 of 2 residents sampled for record review.

The findings include:

Record review for Resident #10 revealed a female admitted on . Her diagnosis included: and D deficiency. Review of the Health Assessment (1823) revealed she was alert with . She was ambulatory with walker and independent with dressing, eating, , toileting and stand by assist for bathing. The assessment also stated she needed precautions, had mild , and needed assistance with self administration of medications.

On Resident #10 had a . On she complained of left hip pain and was transferred to the hospital. She was admitted to the hospital with pelvis and left hip. After consult with surgeon it was determined to take non approach. Review of the hospital discharge summary dated revealed she would be non weight bearing for 2-3 months. The physician documented he had discussion with the daughter, she requested the resident return to the ALF regardless of her condition. The daughter did not want her to go to SNF and requested care. Also the daughter was made aware that her mother would not get the level of care at the ALF and his prediction that she would decline.

In 2016 Resident #10 had resulting in of right hip. She was transferred to hospital and then to skilled nursing facility(SNF) for rehabilitation. She returned to the facility on . Review of the 1823 from the readmission revealed her diagnoses included: right hip with repair, , acute , , , and failure. It stated she was , could not follow conversation, but could answer simple questions. Nursing and services required included: physical , occupational , speech , medication administration, total care for activities of daily living (ADL's) including eating. Review of the signature page on the 1823 found the physician did not indicate on the form (left blank) what type assistance was needed regarding

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medications.

An interview was conducted with administrator on at 1:29pm. When asked if the facility employed licensed nurse to administer medications, she stated "no". When asked how the facility ensured Resident #10 was administered medications upon her return to the facility on , she said she would need to review the 1823. After review, she stated the 1823 was not accurate and should have been corrected, she did not need her medications administered. She was asked if the 1823 indicated Resident #10 required total care including eating. She stated "yes". She was asked how the facility able to provide that level of care. She stated the resident was small woman and could be cared for by the staff. She was asked if the facility employed Certified Nursing Assistants (CNA), she stated they have a few, and the rest were caregivers.

She was asked who made the decision regarding Resident #10's return to the facility on , and confirmed she made the decision. The resident had been at the facility since 2015 and her daughter did not want her to go to SNF when she was discharged from the hospital. The administrator was aware Resident #10 had a pelvis and left hip. She said the Home Health nurse was providing guidance to staff on how to safely move and position the resident. She was asked to provide training records regarding what training was provided and what staff attended.

She proceeded to request the training records from the Home Health company, and returned with the sign in sheet which indicated training was provided 2/8 and . She stated the home health agency provided her the dates, she wrote the dates on the training form and had the staff on duty the date of the survey (to sign the form indicating they attended). The administrator was asked why she allowed Resident #10 to return to the facility when she required a higher level of care, she stated her daughter did not want her to go to SNF. Additionally, she confirmed resident #10 was not under the care of any area Hospice providers.

An interview was conducted with Community Director (facility manager) on at 2:03pm. She confirmed she was employed at the facility when Resident #10 had a with hip in 2016. When asked if she was aware that when Resident #10 returned to the facility that she required total care and her medications administered, she stated she was aware, however the administrator determines if a resident can return. When asked if the facility employs licensed nurse to administer medications, she stated "no". When asked who gave Resident #10 her medications, she stated the medication technicians (MT). When asked if the caregivers were CNA's, she stated some of them, and confirmed that the Home health agency provided the staff education on how to assist Resident #10 with ADL's. She said they were instructed to lift her under the arms and legs to lift her.

On at 3:10pm, Resident #10 was observed sitting in a recliner chair in the . She was

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attempting to get up unassisted and a chair alarm sounded. Two staff arrived and lifted her under the arms and pulled her back in the chair.

On the facility faxed a request to the physician to get Resident#10 up out of bed. The physician gave an order resident could get out of bed into wheelchair to go to the dining showers only and as long as she was non weight bearing. On an order was obtained for hospital bed. On an order was obtained for heel for and alternating pressure , . On , an order given for , cream to four times a day for redness due to incontinence.

On at 9:05am, Resident#10 was observed in bed assisted by two caregivers. There was a sign over the bed that stated resident must have 2 person assist at all times. The Medication Technician (MT) (Emp A) was in the the time giving the resident medication. During an interview with the MT at 9:10am, she was asked if the resident gets out of bed. She said she had been getting up for meals. She also had been in bed for several weeks because she and her pelvis and hip. She stated the residents daughter wanted her to return to the facility. She stated the resident can not bear weight and required 2 person assist to provide care, transfers and to get out of bed. When asked if the resident could participate in any activities of daily living, she stated only eating and sometimes we have to assist. She also stated the resident was very . When asked if the resident complained of pain, she stated she was in a lot of pain when she first came back, it was difficult to move her. She received Norco (pain medication) four times a day.

An interview was conducted with Resident Caregiver (EmpB) on at 3:30pm. When asked how often Resident #10 gets up and sits in recliner chair, she stated she was in the wheelchair when she came in and she and another staff placed her in recliner chair, and she will stay there until dinner. Then they put her back in wheelchair to go to the table. She remains in the wheelchair after supper and stays out to watch TV. She stated the resident had become restless lately and trying to get up numerous times by her self. When asked how the staff transfered the resident, she said there needs to be two staff and they take her under her arms and turn her to sit. She stated she is not suppose to put weight on legs. When asked if Resident #10 complained of pain, she stated the first three weeks she was in bed because she was in too much pain to move her. She said she seems to have less pain now.

An interview was conducted with the administrator on at 3:15pm. When asked if there was a physician order for Resident #10 to be up out of bed all day. She stated she would need to review. After review she stated the order had not changed and the current order is for the resident to be out of bed in the wheelchair for meals and bathing only. She was informed the resident was sitting in recline chair in day . She stated Resident #10 was becoming more active and trying to get up by herself and the staff needed to be able to see her. She confirmed Resident #10's physician had not been asked to reevaulate her yet and that would need to be done.

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Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation and staff interview, the facility failed to ensure a copy of the Resident Bill of Rights and the telephone number for lodging complaints against a facility or facility staff was be posted in full view in a common area accessible to all residents.

The findings include:

Observations in the facility on at 8:45 AM found no evidence the facility had posted Resident Bill of Rights or the phone numbers to lodge complaints.

The Administrator was asked on at 11:20 AM where the required phone numbers and Resident Rights were posted. The Administrator took the surveyor out the back of the facility on to a screened porch. A code was needed to access the area. The Resident Rights and a poster with Ombudsman information was on a wall on the porch. The Administrator confirmed they were not located any where else in the facility nor were the other required phone numbers.

Class III

0052 Medication - Assistance with Self-Admin

Based on record review and staff interview, the facility failed to ensure assistance with self administration of as needed medication was given according to 429.256, F.S., for 1 of 5 sampled residents (Resident # 13), related to unlicensed staff providing anti medication to a resident with

The findings include:

Record review for Resident #13 found he was admitted to the facility on . Record review of the most recent AHCA 1823 based on a exam date found his or behavioral status was documented as " ." There was unclear instructions under Section 2-B which had a circel around the box for "needs assistance with self- administration", and a check in the box for "needs medication administration".

Resident #13 was observed in the main dining/activity area on at 3:10 PM. He was asked how

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he was doing. He stated, "Is doing what like dancing." He was then asked how he was feeling. He started fiddling with his pant leg. He started talking about last week. It was unclear what he was saying and he was unable to engage in converation.

Further record review for Resident #13 found he had an order for , / 0.25 milligrams, with instruction to take one tablet as needed for . Record review of the , medication observation record for Resident #13 found he was receiving the as needed each day at 4:00 PM.

The Community Director was asked if the resident was able to request the as needed himself, in an interview at 3:00 PM on . She stated the resident could not say he was and needed the . She stated that the Medication Techs (unlicensed staff who assisted in medication self administration) would call the resident's daughter and she would decide if he should have the medication.

Class III

0083 Training - First Aid and

Based on record review and staff interview, the facility failed to ensure one staff member with current , , ( ) and First Aid training was working at the facility at all times.

The findings include:

Record review of the personnel files were completed on and compared to the schedule for the week of to .

Records showed that Employee M, a caregiver, was held current and First Aid certification and worked the 7 to 3 shift, fufilling the requirement, but was not working on . On that day, Employee N was working and she held First Aid Certification, as well as Employee E who held certification.

Employee B's record showed she held current certification in First Aid and . She was working the 3 to 11 shift on the schedule, but was not working , , or .

The last shift, from 11 PM to 7 AM, was covered by 2 employees each day of the week, and Employees M and B were not scheduled on any of those shifts.Employees E and N were not working together on any other shifts to fufill the requirement besides .

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The Administrator was asked to provde evidence that the employees working on the days Employees E, M, N, and B were not working had current certification in First Aid and .

She confirmed during an interview with on at 3:00 PM that there was no evidence to show that any other employee on the schedule besides Employees E, M,N, and B. This left every 11 to 7 shift for the week without coverage, as well as the 3 to 11 shift from to .

Class III

0085 Training - Nutrition & Food Service

Based on employee record review and staff interview, the facility failed to ensure the food service designee for the facility obtained annually a minimum of 2 hour continuing education in food service and nutrition. (Administrator).

The findings include:

During an interview with the Administrator on at 12:05 PM, she stated she was responsible for food service at the facility. She was asked to provide evidence of her most recent food service training and she provided a Food Safety Manager Certificate. Record review of the certificate found it was dated .

The findings were confirmed during an interview with the Administrator on at 12:05 AM. She confirmed she did not have food service related training since .

Class III

0162 Records - Resident

Based on record review and staff interview, the facility failed to record resident weights semi-annually for 1 of 2 sampled residents. (Resident #10)

The findings include:

1. Record review for Resident #10 revealed weights were recorded as 99 pounds on and 107 pounds on . There were no other weights found.

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An interview was conducted with the facility manager on [redacted] at 3:05pm. When asked if Resident #10 had been weighed every six months, She stated "no" she thought weights only needed to be done yearly.

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0000 Initial Comments

An unannounced biennial licensure survey was conducted at Sarah House (License #12649) on , 2017.

Sarah House had deficiencies found at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and staff interview, the facility failed to obtain accurate and complete AHCA 1823's (used for resident health assessment) for 2 of 2 sampled residents. (Resident #13 and #10)

The findings include:

1. Record review for Resident #13 found he was admitted to the facility on . Record review of the most recent AHCA 1823 based on a exam found "Needs Medication Administration" was checked, and the square next to "Needs Assistance with Self Administration of Medication" was circled, making it unclear which entry was correct.

The Administrator was shown the AHCA 1823 on at 3:05 PM confirmed the AHCA 1823 was the most recent and obtained when the resident was sent out to the hospital due to a and hip .

2. Record review for Resident #10 revealed she was admitted on . Her diagnosis included: , , , and D deficiency. Review of the 1823 from admission revealed she was alert with . She was ambulatory with walker and independent with dressing, eating, , toileting and stand by assist for bathing. Also stated needed precautions, had mild , and needed assistance with self administration of medications.

On , it was documented she returned from a hospital stay for -intestianl . Review of the Health Assessment dated was found incomplete, since the physician did not document (left blank) the type of assistance required for medications.

On Resident #10 returned from the hospital after treatment for right hip . Review of the 1823 dated revealed the resident required skilled services, total care, and administration of medications (which required a licensed nurse).The physician documented on the signature page, Resident #10 required medication administration.

In an interview with the administrator on at 3:15 PM, the contents of the 1823 were confirmed.

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She stated that the 1823 was inaccurate and should have been corrected. Resident #10 did not require medication administration.

Class III

0010 Admissions - Continued Residency

Based on record review, observations and staff interview the facility administrator failed to determine the appropriateness for admission for resident (Resident #10) requiring higher level of care for 1 of 2 residents sampled for record review.

The findings include:

Record review for Resident #10 revealed a female admitted on . Her diagnosis included: and D deficiency. Review of the Health Assessment (1823) revealed she was alert with . She was ambulatory with walker and independent with dressing, eating, , toileting and stand by assist for bathing. The assessment also stated she needed precautions, had mild , and needed assistance with self administration of medications.

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medications.

An interview was conducted with administrator on at 1:29pm. When asked if the facility employed licensed nurse to administer medications, she stated "no". When asked how the facility ensured Resident #10 was administered medications upon her return to the facility on , she said she would need to review the 1823. After review, she stated the 1823 was not accurate and should have been corrected, she did not need her medications administered. She was asked if the 1823 indicated Resident #10 required total care including eating. She stated "yes". She was asked how the facility able to provide that level of care. She stated the resident was small woman and could be cared for by the staff. She was asked if the facility employed Certified Nursing Assistants (CNA), she stated they have a few, and the rest were caregivers.

She was asked who made the decision regarding Resident #10's return to the facility on , and confirmed she made the decision. The resident had been at the facility since 2015 and her daughter did not want her to go to SNF when she was discharged from the hospital. The administrator was aware Resident #10 had a pelvis and left hip. She said the Home Health nurse was providing guidance to staff on how to safely move and position the resident. She was asked to provide training records regarding what training was provided and what staff attended.

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On at 3:10pm, Resident #10 was observed sitting in a recliner chair in the . She was

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attempting to get up unassisted and a chair alarm sounded. Two staff arrived and lifted her under the arms and pulled her back in the chair.

On the facility faxed a request to the physician to get Resident#10 up out of bed. The physician gave an order resident could get out of bed into wheelchair to go to the dining showers only and as long as she was non weight bearing. On an order was obtained for hospital bed. On an order was obtained for heel for and alternating pressure . On , an order given for cream to four times a day for redness due to incontinence.

On at 9:05am, Resident#10 was observed in bed assisted by two caregivers. There was a sign over the bed that stated resident must have 2 person assist at all times. The Medication Technician (MT) (Emp A) was in the the time giving the resident medication. During an interview with the MT at 9:10am, she was asked if the resident gets out of bed. She said she had been getting up for meals. She also had been in bed for several weeks because she and her pelvis and hip. She stated the residents daughter wanted her to return to the facility. She stated the resident can not bear weight and required 2 person assist to provide care, transfers and to get out of bed. When asked if the resident could participate in any activities of daily living, she stated only eating and sometimes we have to assist. She also stated the resident was very . When asked if the resident complained of pain, she stated she was in a lot of pain when she first came back, it was difficult to move her. She received Norco (pain medication) four times a day.

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An interview was conducted with the administrator on at 3:15pm. When asked if there was a physician order for Resident #10 to be up out of bed all day. She stated she would need to review. After review she stated the order had not changed and the current order is for the resident to be out of bed in the wheelchair for meals and bathing only. She was informed the resident was sitting in recline chair in day . She stated Resident #10 was becoming more active and trying to get up by herself and the staff needed to be able to see her. She confirmed Resident #10's physician had not been asked to reevaulate her yet and that would need to be done.

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Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation and staff interview, the facility failed to ensure a copy of the Resident Bill of Rights and the telephone number for lodging complaints against a facility or facility staff was be posted in full view in a common area accessible to all residents.

The findings include:

Observations in the facility on at 8:45 AM found no evidence the facility had posted Resident Bill of Rights or the phone numbers to lodge complaints.

The Administrator was asked on at 11:20 AM where the required phone numbers and Resident Rights were posted. The Administrator took the surveyor out the back of the facility on to a screened porch. A code was needed to access the area. The Resident Rights and a poster with Ombudsman information was on a wall on the porch. The Administrator confirmed they were not located any where else in the facility nor were the other required phone numbers.

Class III

0052 Medication - Assistance with Self-Admin

Based on record review and staff interview, the facility failed to ensure assistance with self administration of as needed medication was given according to 429.256, F.S., for 1 of 5 sampled residents (Resident # 13), related to unlicensed staff providing anti medication to a resident with

The findings include:

Record review for Resident #13 found he was admitted to the facility on . Record review of the most recent AHCA 1823 based on a exam date found his or behavioral status was documented as " ." There was unclear instructions under Section 2-B which had a circel around the box for "needs assistance with self- administration", and a check in the box for "needs medication administration".

Resident #13 was observed in the main dining/activity area on at 3:10 PM. He was asked how

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he was doing. He stated, "Is doing what like dancing." He was then asked how he was feeling. He started fiddling with his pant leg. He started talking about last week. It was unclear what he was saying and he was unable to engage in converation.

Further record review for Resident #13 found he had an order for , / 0.25 milligrams, with instruction to take one tablet as needed for . Record review of the , medication observation record for Resident #13 found he was receiving the as needed each day at 4:00 PM.

The Community Director was asked if the resident was able to request the as needed himself, in an interview at 3:00 PM on . She stated the resident could not say he was and needed the . She stated that the Medication Techs (unlicensed staff who assisted in medication self administration) would call the resident's daughter and she would decide if he should have the medication.

Class III

0083 Training - First Aid and

Based on record review and staff interview, the facility failed to ensure one staff member with current , , ( ) and First Aid training was working at the facility at all times.

The findings include:

Record review of the personnel files were completed on and compared to the schedule for the week of to .

Records showed that Employee M, a caregiver, was held current and First Aid certification and worked the 7 to 3 shift, fufilling the requirement, but was not working on . On that day, Employee N was working and she held First Aid Certification, as well as Employee E who held certification.

Employee B's record showed she held current certification in First Aid and . She was working the 3 to 11 shift on the schedule, but was not working , , or .

The last shift, from 11 PM to 7 AM, was covered by 2 employees each day of the week, and Employees M and B were not scheduled on any of those shifts.Employees E and N were not working together on any other shifts to fufill the requirement besides .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968816	03/01/2017
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)

The Administrator was asked to provde evidence that the employees working on the days Employees E, M, N, and B were not working had current certification in First Aid and .

She confirmed during an interview with on at 3:00 PM that there was no evidence to show that any other employee on the schedule besides Employees E, M,N, and B. This left every 11 to 7 shift for the week without coverage, as well as the 3 to 11 shift from to .

Class III

0085 Training - Nutrition & Food Service

Based on employee record review and staff interview, the facility failed to ensure the food service designee for the facility obtained annually a minimum of 2 hour continuing education in food service and nutrition. (Administrator).

The findings include:

During an interview with the Administrator on at 12:05 PM, she stated she was responsible for food service at the facility. She was asked to provide evidence of her most recent food service training and she provided a Food Safety Manager Certificate. Record review of the certificate found it was dated .

The findings were confirmed during an interview with the Administrator on at 12:05 AM. She confirmed she did not have food service related training since .

Class III

0162 Records - Resident

Based on record review and staff interview, the facility failed to record resident weights semi-annually for 1 of 2 sampled residents. (Resident #10)

The findings include:

1. Record review for Resident #10 revealed weights were recorded as 99 pounds on and 107 pounds on . There were no other weights found.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968816	**03/01/2017**
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)

An interview was conducted with the facility manager on [redacted] at 3:05pm. When asked if Resident #10 had been weighed every six months, She stated "no" she thought weights only needed to be done yearly.

Class III