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 _____	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SARAH HOUSE IV (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 relicensure survey in conjuction with complaint survey (complaint #2022004470 and #2022006282) was conducted at Sarah House IV on 02/05/2024 There were deficiencies identified at the time of the survey.	A 000		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	A 032		

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A 032	Continued From page 1 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation related to elopement risks was accurate according to its own company policy. This had potential to affect 10 of 31 currents residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) identified as elopement risks.	A 032		

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A 032	Continued From page 2 The findings include: On 2/5/2024, a binder with the facility's records regarding elopements was reviewed. During an interview on 2/5/2024 at 3:53pm with the Administrator, she stated if the resident was assessed an elopement risk, it would be put on a task sheet. She was asked to provide a copy of the task sheet for current residents identified as elopement risks. She replied, "I don't have anyone on there." The Administrator was shown the admissions assessment identifying Resident #2 as an elopement risk. Upon seeing the documentation she replied, "Oh yeah, you're right." She was asked if there was a task sheet for Resident #The Administrator responded that there wasn't one for Resident #2. She was asked to identify all of the current residents who were considered elopement risks. She provided the survey team with documentation identifying Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 as elopement risks. Again it was confirmed that task sheets were not completed for these sampled residents. CLASS III	A 032		
A 078	59A-36.010(2) FAC Staffing Standards - Staff (2) STAFF. (a) Within 30 days after beginning employment, newly hired staff must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable disease. The examination performed by the health care provider must have been conducted no earlier than 6 months before	A 078		

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A 078	Continued From page 3 submission of the statement. Newly hired staff does not include an employee transferring without a break in service from one facility to another when the facility is under the same management or ownership. 1. Evidence of a negative tuberculosis examination must be documented on an annual basis. Documentation provided by the Florida Department of Health or a licensed health care provider certifying that there is a shortage of tuberculosis testing materials satisfies the annual tuberculosis examination requirement. An individual with a positive tuberculosis test must submit a health care provider's statement that the individual does not constitute a risk of communicating tuberculosis. 2. If any staff member has, or is suspected of having, a communicable disease, such individual must be immediately removed from duties until a written statement is submitted from a health care provider indicating that the individual does not constitute a risk of transmitting a communicable disease. (b) Staff must be qualified to perform their assigned duties consistent with their level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff must exercise their responsibilities, consistent with their qualifications, to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's health care provider in accordance with this rule chapter. (c) All staff must comply with the training requirements of rule 59A-36.011, F.A.C. (d) An assisted living facility contracting to provide services to residents must ensure that	A 078		

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A 078	Continued From page 4 individuals providing services are qualified to perform their assigned duties in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor must specifically describe the services the staffing agency or contractor will provide to residents. (e) For facilities with a licensed capacity of 17 or more residents, the facility must: 1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and, 2. Maintain time sheets for all staff. (f) Level 2 background screening must be conducted for staff, including staff contracted by the facility to provide services to residents, pursuant to sections 408.809 and 429.174, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 1 out of 4 employee records were reviewed (Employee C) contained evidence of negative tuberculosis (TB) examination upon hire. The findings include. Review of personnel file for Employee C, Resident Care Aide (RCA), indicated that she was hired on 11/27/23. Review of the physical examination paperwork dated 11/28/23 indicated that RCA C failed to return to have the TB skin test read. Photographic evidence obtained. Results were not located anywhere else in the file. An interview was conducted with the Administrator on 02/05/24 at 1:53 pm. She confirmed that the employee did not return to have the TB test read because she had not transportation.	A 078		

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A 078	Continued From page 5 Class III	A 078		
A 081	429.52(1 & 7) FS; 59A-36.011(2-3) FAC Training - Staff In-Service 429.52 (1)(a) Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee ' s personnel record. (b) Each assisted living facility employee must complete the training required under s. 430.5025. However, an employee of an assisted living facility licensed as a limited mental health facility under s. 429.075 is exempt from the training requirements under s. 430.5025(4)(d). (c) If an assisted living facility employee completes the 1-hour training required under s. 430.5025 before interacting with residents, such training may count toward the 2 hours of preservice orientation required under paragraph (a). (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice	A 081		

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A 081	Continued From page 6 training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record. (d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in infection control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its infection control policies and procedures when offering this training. Documentation of	A 081		

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A 081	Continued From page 7 compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident abuse, neglect, and exploitation. The facility must use its abuse prevention policies and procedures when offering this training. (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty	A 081		

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A 081	Continued From page 8 (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that 1 of 4 employees reviewed (Employee C) completed training orientation before interaction with the residents. The findings include: Review of personnel file for Employee C, Resident Care Aide (RCA),indicated that she was hired on 11/27/23. There was no documentation that this employee had completed the preservice training. Records other required trainings were missing. A checklist was located in her record which showed many missing training items. Photographic evidence obtained. During an interview with the Administrator on 02/05/24 at 1:53 pm, she confirmed Employee C was a full time employee and worked 4-5 days a week. She also confirmed that she could not find any training certificate for this employee. Class III	A 081		

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A 086	Continued From page 9	A 086		
A 086	59A-36.011(10) FAC Training - ADRD (10) ALZHEIMER'S DISEASE AND RELATED DISORDERS ("ADRD") TRAINING REQUIREMENTS. Facilities which advertise that they provide special care for persons with ADRD, or who maintain secured areas as described in Chapter 4, Section 464.4.6 of the Florida Building Code, as adopted in rule 61G20-1.001, F.A.C., Florida Building Code Adopted, must ensure that facility staff receive the following training. (a) Facility staff who interact on a daily basis with residents with ADRD but do not provide direct care to such residents and staff who provide direct care to residents with ADRD, shall obtain 4 hours of initial training within 3 months of employment. Completion of the core training program between April 20, 1998 and July 1, 2003 shall satisfy this requirement. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Initial training, entitled "Alzheimer's Disease and Related Disorders Level I Training," must address the following subject areas: 1. Understanding Alzheimer's disease and related disorders; 2. Characteristics of Alzheimer's disease; 3. Communicating with residents with Alzheimer's disease; 4. Family issues; 5. Resident environment; and, 6. Ethical issues. (b) Staff who have successfully completed both the initial one hour and continuing three hours of ADRD training pursuant to sections 400.1755, 429.917 and 400.6045(1), F.S., shall be considered to have met the initial assisted living facility Alzheimer's Disease and Related	A 086		

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A 086	Continued From page 10 Disorders Level I Training. (c) Facility staff who provide direct care to residents with ADRD must obtain an additional 4 hours of training, entitled "Alzheimer's Disease and Related Disorders Level II Training," within 9 months of employment. Facility staff who meet the requirements for ADRD training providers under paragraph (g) of this subsection, will be considered as having met this requirement. Alzheimer's Disease and Related Disorders Level II Training must address the following subject areas as they apply to these disorders: 1. Behavior management, 2. Assistance with ADLs, 3. Activities for residents, 4. Stress management for the care giver; and, 5. Medical information. (d) A detailed description of the subject areas that must be included in an ADRD curriculum which meets the requirements of paragraphs (a) and (b) of this subsection, can be found in the document "Training Guidelines for the Special Care of Persons with Alzheimer's Disease and Related Disorders," dated March 1999, incorporated by reference, available from the Department of Elder Affairs, 4040 Esplanade Way, Tallahassee, Florida 32399-7000. (e) Direct care staff shall participate in 4 hours of continuing education annually as required under section 429.178, F.S. Continuing education received under this paragraph may be used to meet 3 of the 12 hours of continuing education required by section 429.52, F.S., and subsection (1) of this rule, or 3 of the 6 hours of continuing education for extended congregate care required by subsection (7) of this rule. (f) Facility staff who have only incidental contact with residents with ADRD must receive general written information provided by the facility on	A 086		

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A 086	Continued From page 11 interacting with such residents, as required under section 429.178, F.S., within three (3) months of employment. "Incidental contact" means all staff who neither provide direct care nor are in regular contact with such residents. (g) Persons who seek to provide ADRD training in accordance with this subsection must provide the department or its designee with documentation that they hold a Bachelor's degree from an accredited college or university or hold a license as a registered nurse, and: 1. Have 1 year teaching experience as an educator of caregivers for persons with Alzheimer's disease or related disorders, or 2. Three years of practical experience in a program providing care to persons with Alzheimer's disease or related disorders, or 3. Completed a specialized training program in the subject matter of this program and have a minimum of two years of practical experience in a program providing care to persons with Alzheimer's disease or related disorders. (h) With reference to requirements in paragraph (g), a Master's degree from an accredited college or university in a subject related to the content of this training program can substitute for the teaching experience. Years of teaching experience related to the subject matter of this training program may substitute on a year-by-year basis for the required Bachelor's degree referenced in paragraph (g). This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that 4 of 4 employees whose records were reviewed completed Alzheimer's Disease and Related Disorders Level I and Level II Training. The findings include:	A 086		

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A 086	Continued From page 12 Personnel file review for the Administrator showed a hire date of 12/4/2017. Employee A, Medication Technician (Med tech) was hired 11/4/21, Employee B, Resident Care Aide (RCA), was hired 11/16/21, and Employee C, RCA, was hired 11/27/23. Alzherimer's and Related Disorder Training Level I was not completed by the Administrator, Employees A, B, or C. The Administrator, Employee A, and Employee B did not have evidence in their record of having completed the Level II training. Review of the facility's website at (https://daytonaassistedliving.com/) accessed on 02/05/24 at 1:46 pm indicated that the facility advertised for dementia care. Photographic evidence obtained. In an interview on 02/05/24 at 1:15 pm, Employee A stated that most of the residents in the facility had Alzheimer and dementia. She said "Only two- three residents are alert and oriented." During interview with the Administrator on 02/05/24 at 2:24 pm, she stated that the facility offered dementia in-services . She said, "actually I have residents that have dementia here." When asked for the training, she confirmed that the the facility did not provide Level I and Level II training . She revealed copies of dementia training in-services (Photographic evidence obtained) and stated that all the staff were provided the in-services. She confirmed that the in-service did not meet the Level I and Level II training requirements. Class III	A 086		

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A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2020-2025, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current table of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2019, which are incorporated by reference and available for review at: https://ods.od.nih.gov/HealthInformation/Dietary_Reference_Intakes.aspx. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and	A 093		

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 _____	02/05/2024

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A 093	Continued From page 14 date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly	A 093		

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A 093	Continued From page 15 distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of calculating the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on hand. (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has contracted with residents to serve, must be on hand at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain a 3-day supply of nonperishable food, on hand at all times. This had potential for a negative outcome for its current census of 31 residents. The findings include: During a tour of the facility on 2/5/2024 at 1:27pm of the dry storage and food pantry with the Cook/Certified Dietary Manager, there were concerns with the amount of food observed. She was asked if the food present was sufficient for	A 093		

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A 093	Continued From page 16 three meals a day for three days for the current census of 31. She stated there wasn't enough food on hand because she used a lot of it and was waiting on a food delivery. She confirmed the food observed was the only food available and that she wasn't aware of an emergency food. When asked she could not provide a date for the delivery. During an interview on 2/5/2024 1:55pm, the Administrator stated there was emergency food and water in the attic, she referred to it as "military food" adding "it's the kind you prepare with a drop of water." A tour of the attic was conducted on 2/5/2024 at 2:20pm with the Shift Leader. She pointed out a supply of water bottles (10 24 packs of 16 oz bottles). There was no observation of any food. She explained she had been in the attic before and had never seen any emergency food in that area. During an interview on 2/5/2024 with the Administrator she was advised of the observations. She replied "that food should have been up there." In a later interview at 5:43pm she confirmed there was no emergency food in the attic. CLASS III	A 093		