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
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A biennial re-licensure survey was conducted at Savannah Grand Of Amelia Island Assisted Living Facility on . The facility had deficiencies at the time of the survey.	A 000		
A 008	429.26(.) FS; 59A-36.006(2) FAC Admissions - Health Assessment 429.26 (4) If possible, each resident shall have been examined by a licensed physician, a licensed physician assistant, or a licensed nurse practitioner within 60 days before admission to the facility. The signed and completed medical examination report shall be submitted to the owner or administrator of the facility who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission and continued stay in the facility. The medical examination report shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6. (5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a	A 008		

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
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 008	Continued From page 1	A 008		

permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.
(6) Any resident accepted in a facility and placed by the department or the Department of Children and Families shall have been examined by medical personnel within 30 days before placement in the facility. The examination shall include an assessment of the appropriateness of placement in a facility. The findings of this examination shall be recorded on the examination form provided by the agency. The completed form shall accompany the resident and shall be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or [illegible] nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident providing it was completed within 90 days prior to admission to the facility. The applicable department shall provide to the facility administrator any information about the resident that would help the administrator meet his or her responsibilities under subsection (1). Further, department personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 008	Continued From page 2 applicable department shall advise and assist the facility administrator where the special needs of residents who are recipients of [illegible] require such assistance. 59A-36.006 (2) HEALTH ASSESSMENT. As part of the admission criteria, an individual must undergo a [illegible]-to-[illegible] medical examination completed by a health care provider as specified in either paragraph (a) or (b) of this subsection. (a) A medical examination completed within 60 calendar days before the individual's admission to a facility pursuant to section 429.26(4), F.S. The examination must address the following: 1. The physical and mental status of the resident, including the identification of any health-related problems and functional limitations, 2. An evaluation of whether the individual will require supervision or assistance with the activities of daily living, 3. Any nursing or [illegible] services required by the individual, 4. Any special diet required by the individual, 5. A list of current medications prescribed, and whether the individual will require any assistance with the administration of medication, 6. Whether the individual has signs or symptoms of [illegible] or any other communicable [illegible], which are likely to be transmitted to other residents or staff, 7. A statement on the day of the examination that, in the opinion of the examining health care provider, the individual's needs can be met in an assisted living facility; and, 8. The date of the examination, and the name, signature, address, telephone number, and license number of the examining health care	A 008		

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
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 008	Continued From page 3 provider. The medical examination may be conducted by a health care provider licensed under chapter 458, 459 or 464, F.S. (b) A medical examination completed after the resident's admission to the facility within 30 calendar days of the admission date. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities, [illegible], which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09170. Faxed or electronic copies of the completed form are acceptable. The form must be completed as instructed. 1. Items on the form that have been omitted by the health care provider during the examination may be obtained by the facility either orally or in writing from the health care provider. 2. Omitted information must be documented in the resident's record. Information received orally must include the name of the health care provider, the name of the facility staff recording the information, and the date the information was provided. 3. Electronic documentation may be used in place of completing the section on AHCA Form 1823 referencing Services Offered or Arranged by the Facility for the Resident. The electronic documentation must include all of the elements described in this section of AHCA Form 1823. (c) Any information required by paragraph (a), that is not contained in the medical examination report conducted before the individual's admission to the facility must be obtained by the administrator using AHCA Form 1823 within 30 days after admission. (d) Medical examinations of residents placed by the department, by the Department of Children and Families, or by an agency under contract with	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 008	Continued From page 4 either department must be conducted within 30 days before placement in the facility and recorded on AHCA Form 1823 described in paragraph (b). (e) An assessment that has been conducted through the Comprehensive, Assessment, Review and Evaluation for Long-Term Care Services (CARES) program may be substituted for the medical examination requirements of section 429.26, F.S. and this rule. (f) Any orders issued by the health care provider conducting the medical examination for medications, nursing, therapeutic diets, or other services to be provided or supervised by the facility may be attached to the health assessment. A health care provider may attach a DH Form 1896, Florida Form, for residents who do not wish to be administered in the case of or (g) 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 the examination requirements of this subsection for up to 30 days. However, a resident accepted for temporary emergency placement must be entered on the facility's admission and discharge log and counted in the facility census. A facility may not exceed its licensed capacity in order to accept such a resident. A medical examination must be conducted on any temporary emergency placement resident accepted for regular admission. This Statute or Rule is not met as evidenced by: Based on observation, clinical record review, staff interview and facility policy and procedure the facility failed to ensure the required Agency for Health Care Administration (AHCA) Health Assessment Form was complete for one resident	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 008	Continued From page 5 (#12) out of two sampled residents. Not having complete documentation could negatively affect the provision of care necessary for the resident to maintain their highest wellbeing. The findings include: The medication pass was observed on [redacted] for Resident #12 at 2:20 pm. Employee C assisted the resident with self-administration of the medication by preparing the medication and handing it to her. The resident was able to take the cup of medication and put it in her and swallow it with a drink of water. Review of the clinical record revealed the AHCA Health Assessment Form dated was left blank on page 4, section B. The form read: Does the individual need help with taking his or her medications? Yes or No. This question was not answered. There were boxes to be checked next to the required level of assistance for each of the following statements: Needs assistance with self-administration. Needs medication administration. Able to administer without assistance. No box was checked (Photographic evidence obtained). During the exit conference with the administrator on [redacted] at 7:50 pm, she acknowledged that the Health Assessment Form needs to be complete for each resident. Review of the Resident Agreement form dated revealed it read: 22. Resident Admission: The Resident will be admitted to the Facility according to the admission guidelines in Chapter 58A-5 in the Florida Administrative Code and under the terms of this Agreement. These	A 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 008	Continued From page 6 guidelines include but are not limited to: (b) Health Assessment. Residents will be required to have a -to- medical examination completed by a licensed health care provider at least 60 days prior to admission or within 30 days following admission into the community and every 3 years thereafter, or after a significant change in condition. The examination must be recorded on AHCA Form 1823, Resident Health Assessment for Assisted Living Facilities. (c) Resident Functional Evaluation. A health evaluation must be completed in full by the Facility at the time of admission into the Facility (Photographic evidence obtained). Class III	A 008		
A 052	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, including an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer, from where it is stored, and bringing it to the resident. (b) In the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 052	Continued From page 7 storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a [illegible], including removing the cap of a [illegible], opening the unit dose of [illegible] solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the [illegible]. (h) Using a [illegible] to perform [illegible] level checks. (i) Assisting with putting on and taking off [illegible] stockings. (j) Assisting with applying and removing an [illegible] but not with titrating the prescribed [illegible] settings. (k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device. (l) Assisting with measuring vital signs. (m) Assisting with [illegible] bags. (4) Assistance with self-administration does not include: (a) Mixing, [illegible], converting, or [illegible] medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a [illegible] of the body. (d) Administration of [illegible] preparations. (e) Irrigations or debriding agents used in the treatment of a skin condition. (f) [illegible], [illegible], or [illegible] preparations. (g) Medications ordered by the physician or	A 052		

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
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 052	Continued From page 8 health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be [illegible] or older, trained to assist with self administered medication pursuant to the training requirements of rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in section 429.256, F.S. and this rule. (b) In addition to the specifications of section 429.256(3), F.S., assistance with self-administration of medication includes, in the presence of the resident, reading the medication label aloud and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 052	Continued From page 9 doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in section 429.256(4), F.S. 1. As used in section 429.256(4)(g), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication. 2. As used in section 429.256(4)(h), F.S., the	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 052	Continued From page 10 terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (g) All trained staff must adhere to the facility's . . . . control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on resident interview, medication pass observations, and staff interviews and facility policy and procedure review the facility failed to ensure the medication technicians prepared medication in the presence of the resident. The findings include: During an interview with Resident #10 on at 11:10 am, when asked what kind of assistance she receives for her medications, she stated, "They bring them to my room in a cup and . . . . them to me and I take them myself." During the medication pass on . . . . . at 2:10 pm Employee E was observed to prepare a medication for Resident #11 at the medication cart in the common area of the facility outside the door of the apartment for Resident #11. She sanitized her , took out one plastic medication cup and set it on top of the medication cart. She opened the Medication Observation Record (MOR) and read it, unlocked the medication cart, took out the medication card, read the label and popped the pill into a plastic cup. She returned the medication card to the medication cart and locked it. She took a water cup and filled it with water. She then took the medication cup and the water to the resident's room. She knocked on the door and was given	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 052	Continued From page 11	A 052		

permission to enter. She walked over to the resident who was seated in her wheelchair outside on her patio. The medication technician told Resident #11 she had her , and the resident expressed understanding. The resident took the medication cup from Employee E and swallowed the pills. The resident took the water cup and drank the water. She thanked Employee E and Employee E then left the room.

During the medication pass on . . . . . at 2:10 pm Employee C was observed to prepare a medication for Resident #12 at the medication cart in the common area of the memory care unit, just outside the door of the apartment for Resident #12. She sanitized her , took out one plastic medication cup and set it on top of the medication cart. She opened the MOR and read it, unlocked the medication cart, took out the medication card, read the label and popped the pill into a plastic cup. She returned the medication card to the medication cart and locked it. She took a water cup and filled it with water. She then took the medication cup and the water to the resident's room. She knocked on the door and was given permission to enter. She walked over to the resident who was seated in her wheelchair in her sitting room. The medication technician told Resident #12 she had her . . . and the resident expressed understanding. The resident took the medication cup from Employee C and swallowed the pills. The resident took the water cup and drank the water. She thanked Employee C and Employee C then left the room.

During an interview with Employee D on . . . . . at 3:40 pm, she stated that she started working at this facility in , . She has received the training for assistance with self-administration of medication once since she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 052	Continued From page 12 started. She stated the pharmacy nurse providing the training did not teach them to prepare the medication in front of the resident. During an interview with the Health and Wellness Director on at 3:55 pm, she stated she started working at this facility in . She has attended one training for the staff provided by pharmacy nurse on assistance with self-administration of medication. The trainer from the pharmacy did not train the staff to prepare the medication in the presence of the resident. She had not ever heard that before. During an interview with the Administrator on at 7:55 pm, she stated she did recall that the regulation says that the medications must be prepared in the presence of the resident. She was shown the resident agreement form in which it states the same verbiage as the State Statute. She acknowledged. Review of the facility Resident Agreement form revealed it read: Assistance with Self-Administration of Medication: This is defined as taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident; in the presence of the resident, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container; placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . Class III	A 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 092	Continued From page 13	A 092		
A 092	59A-36.012(1) FAC Food Service - General Responsibilities (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator, or an individual designated in writing by the administrator, must be responsible for total food services and the day-to-day supervision of food services staff. In addition, the following requirements apply: (a) If the designee is an individual who has not completed an approved assisted living facility core training course, such individual must complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service. The designee is not subject to the 1 hour in-service training in safe food handling practices. (b) If the designee is a certified food manager, certified dietary manager, registered or licensed dietitian, dietetic registered technician, or health department sanitarian, the designee is exempt from the requirement to complete the food and nutrition services module of the core training course before assuming responsibility for the facility's food service as required in paragraph (1)(a) of this rule. (c) An administrator or designee must perform his or her duties in a safe and sanitary manner. (d) An administrator or designee must provide regular meals that meet the nutritional needs of residents, and therapeutic diets as ordered by the resident's health care provider for residents who require special diets. (e) An administrator or designee must comply with the food service continuing education requirements specified in rule 59A-36.011, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation, staff interviews and facility	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 092	Continued From page 14 policy and procedure review the facility failed to distribute food in a sanitary manner during the lunch meal service. The findings include: The lunch meal service was observed on from 12:18 pm until 1:05 pm in the main dining room. During the service Employees F and Employee G were observed to be clearing away dirty dishes from the tables, taking them into the kitchen, using the resident's dirty utensils to scrape the plates off into a large garbage can. The two staff then took turns and went to the three compartment sink and rinsed the plates and put them aside. After doing so they went to the paper towel roll dispenser and pulled off several towels, dried their , opened the lid of a large garbage can in the kitchen near the door to the dining room. Both would then go to the dining room and immediately serve brownies on a plate to residents. Employee G was observed to put her on two different resident's while speaking to them. She rubbed her with the of her thumb while speaking to one unsampled female resident in the dining room. She did not sanitize her or wash them with soap and water before she went to the juice room to get two glasses of water for residents and take them to their tables. The two staff were not observed to sanitize or wash their during the entire meal service. They were observed to put their on the backs of chairs while speaking with residents and touch various surfaces, resident's glasses and plates without sanitizing their . During an interview with Employee F on at 1:15 pm she stated that she was not washing her in the three compartment	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964598	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF AMELIA ISLAND	1900 AMELIA TRACE COURT FERNANDINA BEACH, FL 32034

(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 092	Continued From page 15 sink. She washes her . . . in the bathroom upstairs or in the juice room. She indicated that there was a . . . sanitizer dispenser located on the pillar holding the stairs up in the main lobby approximately 15 . . . from the kitchen door. When informed that she was not observed to use the sanitizer or the . . . washing sink in the juice room, she stated she had washed her in the bathroom upstairs at least twice today. During an interview with the Administrator on at 5:25 pm she was informed about the observation of lunch and the interview with Employee F. She stated she was not aware that the staff were not sanitizing or washing their after contaminating them. She stated the staff should be sanitizing between residents and washing their if they are touching contaminated surfaces such as the garbage can. Review of the facility policy and procedure entitled Handwashing #508 revealed it read: washing policies are to be in accordance with the Center for Control Guidelines for . . . Washing in Hospitals. Personnel shall wash their : a) Between contacts with different residents when providing direct care ....or any such -on tasks. g) Before assisting with any food service tasks. Class III	A 092		