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
	AL11953284	A. BUILDING: _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF MAITLAND	1301 W. MAITLAND BLVD MAITLAND, FL 32751

(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 Complaint Investigation #2020009383 was conducted on [redacted] and [redacted]. Savannah Court of Maitland had deficiencies identified at the time of the visit.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to follow a health care provider's order for 2 of 7 sampled residents (#3 & #4), and failed to meet the resident's needs by failing to make all efforts to inform a health care provider when 1 of 7 sampled residents (#8) experienced a significant health status change. Findings: 1. Resident #3's current 1823 health assessment form, dated , indicated that her diagnoses included , , and she required assistance with self-administration of medications. A health care provider's order, dated , indicated that she was to take 60 milligrams (mg) 1 tablet by daily, hold for , less than 100. However, the Medication Observation Records (MORs) and the resident's record did not contain documentation of , readings to	A 025		

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A 025	Continued From page 2 indicate the order was followed. (photographic evidence obtained). At 3:45 p.m. on , both the director of nursing (DON) and the administrator confirmed the findings, and both said the order should not have had a parameter. An opportunity was given to provide additional documentation, but they were unable to do so. A health care provider's order, dated , indicated that resident #3 was to take 50 mg. by thirty minutes before twice a week for . A health care provider's order, dated , instructed to discontinue . However, documentation on both the resident's MOR and count sheet revealed she was given the on and , which was after ended. (photographic evidence obtained). Resident #3's record did not contain any orders to continue the and there was no documentation to indicate the facility contacted a health care provider for additional instructions. At 3:50 p.m. on , both the DON and administrator confirmed the findings and despite being given an opportunity to provide additional documentation, were unable to do so. 2. Resident #4's record revealed a facility admission date of . A current health assessment (1823) form, dated , indicated that his diagnoses included and . He required assistance with self-administration of medications, and he was to use 2 liters continuously. (photographic evidence obtained).	A 025		

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A 025	Continued From page 3 Observations made at 3:12 p.m. on revealed the resident was not using and did he have any in his room. His wife, who resides with him in the facility, said he never had since he was admitted to the facility. At 3:55 p.m. on , the findings were discussed with both the DON and the administrator, and both said they were unaware of the order and neither could provide additional documentation. 3. At 9 a.m. on , the administrator identified resident #8 and said the resident was sent to the hospital on , tested positive for Covid-19 ., and , at the hospital. A current 1823 form, dated , indicated that the resident's diagnoses included high and . A facility note, dated , indicated that she continued to have a dry and the resident believed it was due to . A health care provider's order, dated , indicated that she was to have a and 20 mg, a , was to be given daily for 7 days for a and . The , result was negative. A facility note, dated and a day after her last dose, reflected that the resident was not feeling well and had a nominal upon taking a deep breath. She requested to remain in bed. The nurse "prepared and sent a fax" to a health care provider.	A 025		

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A 025	Continued From page 4 A facility note, dated , indicated that she remained in bed and continued to have a non-productive upon taking a deep breath. The nurse "prepared and sent an update to her health care provider." A facility note, dated at 7:25 a.m., indicated that she was in the bed, was very weak, had a non-productive and her temperature was 99.4 degrees. The nurse "prepared and sent a fax" to the health care provider asking if sending the resident to an acute care setting might be prudent. A facility note, dated at 9:03 a.m., indicated that a nurse placed a call to the health care provider's office and there was no answer. A voicemail message was left with details of the nursing assessment. "Awaiting return call." A facility note, dated at 2 p.m., indicated that a health care provider was in the facility to see the resident. A health care provider's order, dated , instructed to send the resident to the emergency room due to an saturation of 72%, , rate of 40 and a . A facility note, dated , indicated the facility called the hospital and were informed the resident tested positive for Covid-19 . At 11:30 a.m. on , nurse F, who was the author of the facility notes dated , and , said he only sent fax communications to a health care provider when the resident's continued, and said he never placed a call to follow-up on receipt of the faxes or to speak	A 025		

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A 025	Continued From page 5 with a health care provider until [redacted]. Review of the resident's entire care record revealed there was no documentation to indicate a health care provider responded to the faxes, and no documentation to indicate anyone called the health care provider to follow-up with the health care provider concerning the resident's condition. At 12:35 p.m. on [redacted], both the administrator and DON confirmed the findings. The DON said the reason the resident was not sent to the hospital for evaluation sooner was because at that time she understood the State said residents could not be sent to the hospital because of the risk to them. They both said a doctor was spoken to regarding the resident's condition prior to [redacted] and were instructed to just monitor the resident. However, neither the administrator nor the DON could remember who spoke with the doctor, and neither could provide documentation to indicate the call took place. At 3:49 p.m. on [redacted], the nurse practitioner who saw the resident in the facility on said the first time she received a message regarding the resident's condition was mid-afternoon on [redacted], and said when she arrived to the facility, the resident's condition was poor, so she instructed the facility to send her to the hospital. Despite the resident's continued dry [redacted] after completion of the [redacted], the facility failed to contact a health care provider by any means other than sending a fax and failed to call the provider when a response to the faxes was not received. In addition, on day three, [redacted] at 7:25 a.m., her symptoms worsened to being "very	A 025		

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A 025	Continued From page 6 weak", her temperature was 99.4 degrees, and again only a fax was sent. Approximately one and a half hours later, a phone call was placed to a health care provider. A message was left, and the nurse waited on a return call. The resident was not seen by a health care provider in the facility until five hours after that call. A hospital history and physical, dated . . . . . , indicated that her admission temperature was 100.3 degrees and a . . . . . , revealed . . . . . airspace opacities consistent with . . . . . versus , ... , ... Covid-19 . . . . . testing was obtained. A hospital lab report, dated . . . . . , indicated that SARS COV 2 PCR Covid19 was detected and she had a positive . . test. A hospital discharge form indicated that she was pronounced . . . . on . . . . . Class II	A 025		
A 030 SS=D	59A-36.007(6) FAC; 429.28( ) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident	A 030		

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A 030	Continued From page 7 complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; . . . . , Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- . . . . or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font. (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident . . . . , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. . . . . control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own	A 030		

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A 030	Continued From page 8 sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and	A 030		

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A 030	Continued From page 9 personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making	A 030		

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A 030	Continued From page 10	A 030		

for health care services, the provision of or arrangement of transportation to health care , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community.
(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.
(2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free

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A 030	Continued From page 11 telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that	A 030		

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A 030	Continued From page 12 which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on observations and interviews, the facility failed to safe guard 82 resident's well-being by failing to follow current control standards related to COVID-19 requirements set forth by the Department of Health (DOH) delineating the universal use of masks and failed to treat 1 of 8 sampled residents (#3) with consideration and respect by failing to respond to calls for assistance in a timely manner. Findings: Observations made at 10:30 a.m. on revealed caregiver B, while assisting residents #1 and #4 with medications in their room, wore a mask down and over only her and stood approximately two from each resident. Observations made at 10:45 a.m. on revealed caregiver C and private duty caregiver D were standing approximately two apart in a hallway, located outside of resident rooms, talking with each other. They both wore a mask down and over only their . When questioned further, caregiver C said, "I just took it down." Caregiver B was present and when asked why she did not wear her mask properly while providing med assistance to residents #1 and #4 she said, "I just realized it's down." At 9:47 a.m. on , resident #3 said she has waited hours at times when she used her pendant to call for help.	A 030		

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A 030	Continued From page 13 Review of her call response times for , and revealed there was a 60-minute response time on /202, 66 minutes on and both 133 minute and 68 minutes on . (photographic evidence obtained). At 12:35 p.m. on , both the director of nursing and administrator confirmed the findings, and neither could explain the lengthy call responses. Class III	A 030		
A 052 SS=D	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 storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section.	A 052		

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A 052	Continued From page 14 (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], or [illegible] preparations. (g) Medications ordered by the physician or 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	A 052		

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A 052	Continued From page 15 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 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	A 052		

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A 052	Continued From page 16 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 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	A 052		

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A 052	Continued From page 17 . . . . control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the unlicensed staff (A & B) who assisted 3 of 4 sampled residents (#1, #4 & #5) with self-administration of medications followed the correct procedures. Findings: 1. Observations made during a medication pass for resident #5 at 9:24 a.m. on revealed unlicensed caregiver A washed her . . ., unlocked the medication cart, then removed medication packs and bottles. While standing at the cart, she poured the medications into a cup, then she placed the packs and bottles . . . into the cart. She locked the cart, then she took just the cup of medications to the resident in his room. She handed the cup to the resident, who took them himself. Caregiver A did not take the medications, in their previously dispensed and properly labeled containers, from the medication cart and bring them to the resident. She did not, in the presence of the resident, read each label aloud and remove the prescribed amount of medication from the containers. Caregiver A confirmed the findings immediately following the medication pass. 2. Observations made at 10:30 a.m. on revealed unlicensed caregiver B had	A 052		

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A 052	Continued From page 18 two cups on top of a medication cart. One cup contained 3 tablets and the other 4 tablets. She took both cups to the room of husband and wife residents #4 and #1. She handed one of the cups to resident #1, who took the meds herself. She approached resident #4, poured the medications into his . . . then she gave him water. Caregiver B did not take the medications, in their previously dispensed and properly labeled containers, from the medication cart and bring them to the residents. She did not, in the presence of the residents, read each label aloud and remove the prescribed amount of medication from the containers. At 10:45 a.m. on . . . . . caregiver B confirmed the findings. Class III	A 052		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is	A 054		

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A 054	Continued From page 19 offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interview, the facility failed to ensure the Medication Observation Record (MOR) for 1 of 7 sampled residents (#1) was properly updated. Findings: Observations made at 10:30 a.m. on revealed caregiver B gave medications to resident #1. However, a MOR was not available in the MOR book for caregiver B to both reference during the medication pass and sign to indicate the medications were given. Observations made at 11:15 a.m. on [illegible] revealed nurse A was writing a MOR for the resident and said a printed one was not received from the pharmacy. Therefore, the MOR was not available at the time of the med pass to be properly updated. Class III	A 054		

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A 056 SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in accordance with chapters 465 and 499, F.S., and rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container: 1. The resident's name; and, 2. The identification of each medicinal drug in the container. (b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another. (c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist. (d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic	A 056		

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A 056	Continued From page 21 copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to section 465.0276(5), F.S., and rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date.	A 056		

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A 056	Continued From page 22 (h) Pursuant to section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order. This Statute or Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to make every reasonable effort to ensure a prescription was filled in a timely manner for 3 of 7 sampled residents (#1, #2 & #3), and failed to ensure "as needed" prescriptions for 2 of 7 sampled residents (#2 & #4) contained the circumstances under which it would be appropriate for the resident to request the medication. Findings: 1. At 12 p.m. on . . . . . , resident #1 said she had not been given her Pradaxa since she was admitted to the facility. Resident #1's record review revealed a facility admission date of . A current 1823 health assessment form, dated . . . . . , indicated that her diagnoses included . . . . . , Displaced Trimalles right . . , non- . . . . valve , ... , Hypertensive . . . . . and . . . . . . She required assistance with self-administration of medications. The 1823 contained a health care provider's order for Pradaxa 150 milligrams (mg.) by twice daily. However, review of the resident's . . Medication Observation Record (MOR) revealed the medication was circled from . through , and documentation	A 056		

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A 056	Continued From page 23 on the MOR indicated the medication was unavailable. "Pradaxa ( ) is an (thrombin inhibitor) that helps prevent the formation of clots. Pradaxa is used to lower the risk of caused by a clot in people with a rhythm called . This medicine is used when the is not caused by a valve problem." (drugs.com). Observations made during a medication pass for resident #1 at 10:30 a.m. on revealed the resident was not given Pradaxa and there was not any available in the medication cart. In addition, the 1823 contained a health care provider's order for the following "as needed" medications: , , , Mirilax, , and , all of which did not contain the circumstances under which it would be appropriate for the resident to request the medication. Review of the resident's entire care record revealed there was no documentation to indicate the facility made any efforts to obtain the Pradaxa and no documentation to indicate a health care provider was contacted to provide revised instructions for the "as needed" medications. 2. Resident #2's current 1823, dated , indicated that her diagnoses included . Review of the resident's , and MORs revealed an entry for 112 micrograms (mcg.) by once daily. The medication was circled on through and on , and documentation on the MORs indicated the	A 056		

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A 056	Continued From page 24 medication was unavailable. "... ... ... is given when your ... does not produce enough of this hormone on its own." (drugs.com). At 2:45 p.m. on ... ..., a review of her medication containers in the cart revealed there was no ... ... available. Review of the resident's entire care record revealed there was no documentation to indicate the facility made any efforts to obtain the ... . 3. At 9:37 a.m. on ..., resident #3 said the facility waits until they run out of her medication before they order more. Resident #3's current 1823, dated ..., indicated that her diagnoses included ... ..., ... and history of a ... ... She required assistance with self-administration of medications. Review of the resident's ... MOR revealed an entry for ... ... 80 mg by ... daily. However, the medication was circled .../202 through ... ..., ... through ... and ... through ..., and documentation on the MOR revealed the medication was unavailable. "... is used together with diet to lower ... levels of "bad" ... (low-density lipoprotein, or ...), to increase levels of "good" ... (high-density lipoprotein, or ...), and to lower triglycerides (a type of fat in the ...)." (drugs.com).	A 056		

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A 056	Continued From page 25 Review of the resident's entire care record revealed there was no documentation to indicate the facility made any efforts to obtain the 4. Resident #4's current 1823, dated , indicated that he required assistance with self-administration of medications. The 1823 contained a health care provider's order for the following "as needed" medications: plus, inhaler and , all of which did not contain the circumstances under which it would be appropriate for the resident to request the medication. Review of the resident's entire care record revealed there was no documentation to indicate a health care provider was contacted to provide revised instructions for the "as needed" medications. At 3:45 p.m. on both the director of nursing and the administrator confirmed the findings. An opportunity was given to them to provide additional documentation to explain the findings, but they were unable to do so. Class III	A 056		
A 078 SS=D	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 . The examination performed by the health care provider must have	A 078		

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A 078	Continued From page 26 been conducted no earlier than 6 months before 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 . . . . . 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 testing materials satisfies the annual . . . . . examination requirement. An individual with a positive test must submit a health care provider's statement that the individual does not constitute a risk of . . . . . . 2. If any staff member has, or is suspected of having, a communicable . . . . . , 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 . . . (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 . . . . . to	A 078		

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A 078	Continued From page 27 provide services to residents must ensure that 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 . . . . . 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 observation and interview, the facility failed to ensure staff were qualified to perform their assigned duties consistent with their level of education, training, preparation and experience by allowing an unlicensed caregiver (B) to administer medications to 1 of 3 sampled residents (#4). Findings: Observations made at 10:30 a.m. on revealed unlicensed caregiver B had two cups on top of a med cart. One cup contained 3 tablets and the other 4 tablets. She took both cups to the room of husband and wife residents #4 and #1. She handed one of the cups to resident #1, who took the medications herself. She approached resident #4, poured the medications into his then she gave him water, which is a task unlicensed staff are not qualified to perform.	A 078		

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
	AL11953284	A. BUILDING: _____ B. WING _____	06/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF MAITLAND	1301 W. MAITLAND BLVD MAITLAND, FL 32751

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A 078	Continued From page 28 At 10:45 a.m. on . . . . . caregiver B confirmed the findings. Class III	A 078		