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 _____	R 11/09/2020

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 second revisit to Complaint Investigation 2020009383 was conducted on . An uncorrected deficiency was identified at the time of the visit.	{A 000}		
{A 025} SS=D	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 or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . 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: DEFICIENCY REMAINED UNCORRECTED Based on record reviews and interview, the facility failed to follow a health care provider's medication order for 2 of 2 sampled residents (#6 and #9). Findings: 1. Review of resident #6's 1823, dated , revealed that he required assistance with self-administration of medications. Review of the resident's Medication Observation Record (MOR) revealed an entry for Budes/Formot AER 160-4.5 mg., inhale two puffs by twice daily and was written below it. The dose on , and were all circled and documentation on the of the MOR indicated "wait on pharmacy," "called pharmacy," "new prescription, send on next run."	{A 025}		

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{A 025}	Continued From page 2 However, documentation on his MOR revealed that he received the same prescription during that month. (photographic evidence obtained.) 2. Review of resident #9's MOR revealed an entry for POT CL MICRO tab 20 meq ER, one tablet by once daily and M20 was written below it. The dose on , , , , , and were all circled and documentation on the of the MOR indicated the medication was not given and was waiting on med from pharmacy. (photographic evidence obtained.) An opportunity was provided to the director of nursing (DON) to provide additional documentation and explanations. At 1:20 p.m. the DON returned and said the medication for both residents was available to be given on those dates but the unlicensed caregivers giving the meds did not understand the entries on the MORs were for and , therefore, they were not given. Additional review of both resident's record revealed there was no documentation to indicate the staff made any attempts to determine which medication was to be given in order to ensure the residents did not miss a dose. Class III	{A 025}		