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
	AL11969281	A. BUILDING: _____ B. WING _____	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVORAH ALF II LLC	2369 SW FERN CIR PORT SAINT LUCIE, FL 34953

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A 000	Initial Comments An unannounced licensure Complaint, #2020007934 and #2020016611, Focused Control and Generator Monitoring survey was conducted on [redacted] at Savorah ALF II LLC. The facility had deficiencies at the time of the survey.	A 000		
A 010	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice,	A 010		

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A 010	Continued From page 1 and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . . . . . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident ' s representative or designee or the resident ' s family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (3) A physician, physician assistant, or advanced	A 010		

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A 010	Continued From page 2	A 010		

practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility.

59A-36.006
(4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to-medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are:
(a) The resident may be bedridden for no more than 7 consecutive days.
(b) A resident requiring care of a may be retained provided that:
1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider,
2. The condition is documented in the resident's record; and,
3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility.
(c) A ill resident who no longer meets

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A 010	Continued From page 3 the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assess residents for	A 010		

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A 010	Continued From page 4 appropriateness of continued residency when the residents', , behavior and repeated elopements interfered with the facility's ability to provide necessary care and services (including supervision) as appropriate, for 3 of 8 sampled Residents (#1, 3 and 7). The findings included: Review of resident records conducted on related to appropriateness of continued residency revealed the following concerns: 1. Review of Resident #7's records conducted on revealed the following. She was admitted to the facility on . Her health assessment documented the following. Her diagnoses included "history of relapse and and , from placement - , history of ". She has , issues, coping skills, relapse prevention for , and is at risk for elopement-leaves and uses substances. The section titled Special Precautions was left blank. She is independent of activities of daily living, and requires daily oversight for whereabouts and well-being. She was discharged from the facility on to another group setting. Review of law enforcement records revealed the following reports related to Resident #7: On at 2:30 AM, a [Resident #7] called 911 and reported her daughter was being molested in Okeechobee County. Upon arrival, [Resident #7] was standing in the driveway, very clearly agitated. She stated her six year old daughter was being molested by her father. She continued to become more agitated. She could not explain how she knows that her daughter is	A 010		

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A 010	Continued From page 5	A 010		

being molested, but that she just knows that she is. When questioned further, she advised she is being watched by a satellite and she knew her daughter was being molested because could hear her screaming. Her family is from Okeechobee, and the State Women's Penitentiary had satellites in the clouds to watch her. She could hear voices of family and correction facility staff in her . She was mandated by court to live here. Contact was made with the manager of the group home, who advised [the resident] was diagnosed as , and , , and her medications recently changed. [The resident] stated voices were telling her to kill herself. It was determined [the resident] was potentially at risk of hurting herself and needed to be further evaluated. She was taken into custody by . While in custody, she become more and more agitated. While in the patrol car, she continued to have conversations with several voices that she advised she was hearing in her . She advised the voices were family members, advising that she was going to kill them when she got out. She was unable to provide supporting information. She stated she spoke with her daughter two weeks prior and the daughter did not make any claims. [The Administrator] confirmed she lived in the home for about one year, and her daughter lived with her in Okeechobee. She stated [the resident] has made frequent similar claims but is unaware of any validity to the claims. Able to obtain limited information about all the involved parties from [the resident] while on scene, due to her state. She was transported to [a mental health crisis stabilization unit] by .

On at 11:22 PM, a report of a disturbance was made. [The Administrator] and [Resident #7] who has , / ,

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according to [the Administrator] and did not take her medications today. [The Administrator] stated [the resident] had been screaming, pushing and punching her in the , having behavioral issues all day, and had also punched [the Administrator's] vehicle during an argument this evening. [The resident] admitted a verbal and physical altercation did take place related to a check she wanted to cash. Ultimately, [the resident] was and transported to [a mental health crisis stabilization unit] without incident. While typing this report, [the resident] was talking to herself in the of the patrol vehicle. When asked if she was okay and what was she saying, she responded she was just talking to the voices in her .

On at 10:29 PM, a report of obscene harassing phone calls was made. Met with [Resident #7] who stated satellite computers can zoom into the house and watch over someone, they hate herself, want her . If she doesn't die today by drinking bleach "they" are going to kill her child and her alive. [The resident] has diagnoses of , with a history of . She also stated that if she asleep, they will kill her baby. She also believes that Okeechobee Sheriff's office and the department of corrections is working with the satellites and the voices in her to make sure she dies in a holding cell. At this point, she was considered a threat to herself if she does not receive medical attention and was taken into custody under a . While typing this report, she was talking to herself saying "I will just kill myself in order to save my baby", and "you just want to see action, please leave me alone", amongst other full on conversations she was having with herself.

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A 010	Continued From page 7 On . . . . . at 5:38 PM, a report of a disturbance was made related to [Resident #7] was . . . . again. She is . . . . and again believing someone is going to . her and . . her baby alive. This time, she was found to have an out of county aggravated assault against other patient at [a mental health crisis stabilization unit]. She was transported to jail and the . . . . paperwork was left there. On . . . . . at 9:30 PM, a report of attempt to contact was made related to [Resident #7]. A caller from the crisis hotline stated she made vague threats to hurt herself. Upon arrival, she advised she could hear the voices screaming and could not get them to stop. She then advised that the same voices told her to kill herself by drinking bleach. She was placed in and transported to [a mental health crisis stabilization unit] under law enforcement without further issue. On . . . . . at 2:28 PM, a report of . . . . . threats was made related to [Resident #7]. The voices in her . . . told her to drink chemicals or else they would kill her daughter ... another resident stopped her ... called [a mental health behavioral center] and threatened , saying her medication was not helping. ... "[the resident's] caretaker stated she had a daughter, but the child does not live with her." She was transported via to [a mental health crisis stabilization unit]. There was no evidence showing the facility took steps to initiate discharge from the facility when it was demonstrated the facility could not maintain the resident's safety due to the resident's repeated elopements. In an interview conducted on at 12:47 PM, the Administrator stated	A 010		

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A 010	Continued From page 8 Resident #7 moved out of the facility to the general community on . She stated the resident was always calling the police saying someone was trying to kill her daughter. She stated she was trying to work with her to help her get stable. She acknowledged the resident's extended history of behaviors and , and confirmed she had not taken steps to initiate a discharge related to the resident's on-going inappropriate behavior. 2. Review of Resident #1's records conducted on revealed the following. She was admitted to the facility on . Her AHCA Form 1823 (health assessment) documented her diagnoses include , high and long-term . She is alert and oriented, independent for all activities of daily living, and is not at risk for elopement. She requires daily oversight for whereabouts and well-being. On at 5:11 PM, according to local law enforcement records, the facility filed a missing persons report for this resident. She was last seen about 4:30 PM, she did not return from her walk. The Administrator stated the resident has a history of walking to her prior residence located in another city which was corroborated by the resident's family member. Law enforcement records documented this resident went missing from this residence and was located by law enforcement on four prior occasions. On at 11:02 AM, according to local law enforcement records, the facility filed another missing persons report for this resident. She was last seen about 9:30 AM. Upon arrival at the facility, the Administrator stated the resident was	A 010		

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A 010	Continued From page 9 last seen after dinner, about 6:00 PM. This is her third reported time leaving the group home this year. She was questioned if there is a reason as to why [Resident #1] keeps _____ off. The Administrator explained that there are several high functioning residents who also live at the above address that cannot be left alone, she is not able to accompany [Resident #1] on her walks and/or provide more one on one attention to her. She stated "we are not paid for one on one care" but agreed this facility is no longer suitable for [Resident #1's] needs. [Resident #1] does not have a cell phone or tracking bracelet and the Administrator stated she refuses to wear one. The resident was found in another county on _____ around 6:48 AM. When asked why she left she stated that they don't let her leave the house and she just wanted to get out. Her resident observation notes included: a. On _____ - The resident eloped in the afternoon. Was found and taken to [mental health facility]. b. On _____ - The resident went missing. Administrator was advised, 911 called ... returned by Sheriff _____ at 8:00 PM. c. On _____ - The resident went for her daily walk, took longer than usual, police and family notified ... was found across town saying she was going home in [other city]. There were no further resident observation notes after _____. There was no evidence showing the facility took steps to initiate discharge from the facility when it was demonstrated the facility could not maintain the resident's safety due to the resident's repeated elopements. In an interview conducted on _____ at 1:46 PM, the Administrator stated the resident doesn't do much, mostly just sits there. She refuses to	A 010		

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A 010	Continued From page 10 hold identification on her person. She acknowledged the lack of documentation showing the resident's multiple elopements had been thoroughly investigated and steps taken to prevent elopement recurrence. Resident #1 was observed during the survey conducted on , mostly sitting or laying on the couch watching TV, or meandering throughout the facility. In an interview with the resident on at 2:17 PM, the resident gave nonsensical responses to questions asked of her, she kept repeating that she was fine. Further record review revealed no documentation showing the facility staff followed the facility's written policies and procedures related to resident elopement prevention and response as per the items listed at the beginning of this citation. No additional information was available at the time of the survey exit. 3. Review of Resident #3's records conducted on revealed the following. She was admitted to the facility on . Her health assessment documented the following. Her diagnoses included , post-symptoms and mental deficiency . She has , left-side , and requires special precautions for and daily oversight for whereabouts and well-being, she is not at risk for elopement. On at 10:36 AM, according to local law enforcement records, the facility filed a missing persons report for this resident. She left the facility without permission around 9:30 AM. Staff C stated after multiple attempts to convince the resident to return to the facility, she followed the	A 010		

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A 010	Continued From page 11 resident in a car to a local gas station before returning to the facility and contacting 911 and the Administrator. Staff C later contradicted herself by saying she walked behind the resident. The resident was promptly located by law enforcement in the next county. Review of Resident #3's records conducted [illegible] revealed the following: Her resident observation notes included: a. On - The resident is alert and has a speech deficiency, she communicates through writing. b. On - The resident continues to refuse medications, only taking [illegible]. c. On - The resident refuses medications a lot. d. On - The resident continues to refuse some of her medications. e. On - The resident went missing at 9:27 AM, the police were called, she was found in Martin county. f. On - The resident went out around 10:30 AM and returned with discharge paperwork from the hospital. g. On - The resident left the facility without permission at 9:50 AM. h. On - The resident left at 9:00 AM and came at 5:50 PM. After two hours, the family was called and said to wait for her. (Please note, there were no further notes related to the outcome of this elopement.) i. On - The resident had a and refused medical attention. j. On - The resident left at 9:45 AM and came at 6:06 PM. She claims she went to Stuart. (Please note, there were no further notes related to the outcome of this elopement.) k. On - The resident had another	A 010		

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A 010	Continued From page 12 [redacted], froth coming out of her [redacted] for about 5 minutes and refused medical attention. I. On [redacted] - The resident left facility without permission at 9:30 with signing. She still refused her medication. (Please note, there were no further notes related to the outcome of this elopement.) Her medication observation records documented she regularly refused most of her medications [redacted] through [redacted]. There was no evidence showing the facility took steps to initiate discharge from the facility when it was demonstrated the facility could not maintain the resident's safety due to the resident's repeated refusals of medications and treatment, and repeated elopements. In an interview conducted on [redacted] at 1:12 PM, these concerns were discussed with the Administrator. She stated the resident has always refused medications. They are trying to get her moved to Oklahoma; someone from the court system is trying to get her into a specialized mental health treatment center. She confirmed she had not taken steps to initiate a discharge related to the resident's on-going inappropriate behaviors. No additional information was available at the time of the survey exit. Class III	A 010		

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CZ830	408.821 FS Emergency Management Planning 408.821 Emergency management planning; emergency operations; inactive license.- (1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows: (a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan. (b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan. (c) Submit necessary plan revisions within 30 days after notification that plan revisions are required. (d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health. (2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers. (3)(a) An inactive license may be issued to a licensee subject to this section when the provider	CZ830		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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
	AL11969281	A. BUILDING: _____ B. WING _____	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVORAH ALF II LLC	2369 SW FERN CIR PORT SAINT LUCIE, FL 34953

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CZ830	Continued From page 1 is located in a geographic area in which a state of emergency was declared by the Governor if the provider: 1. Suffered damage to its operation during the state of emergency. 2. Is currently licensed. 3. Does not have a provisional license. 4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months. (b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes. (4) The agency may adopt rules relating to emergency management planning, communications, and operations. Licensees	CZ830		

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CZ830	Continued From page 2 providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to provide required emergency management planning, communications, and operations by not entering daily required information into the Emergency Status System (ESS) data via the Agency-approved online database. This had the potential to affect all of the facility's current residents. The findings included: Review of the facility's ESS data entry for the period through was conducted on at 11:17 AM. Review of the facility's history of dates and times the facility's ESS data was entered revealed the following discrepancies (photographic evidence obtained): On , no ESS data entry was made for that day On , the ESS data entry was made after 10:00 AM, at 10:28 AM On , the ESS data entry was made after 10:00 AM, at 11:53 AM On , no ESS data entry was made for that day On , the ESS data entry was made after 10:00 AM, at 1:14 PM On , the ESS data entry was made after 10:00 AM, at 2:52 PM On , no ESS data entry was made for that day On , the ESS data entry was made after	CZ830		

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CZ830	Continued From page 3 10:00 AM, at 1:59 PM On , no ESS data entry was made for that day On , the ESS data entry was made after 10:00 AM, at 10:44 AM On , the ESS data entry was made after 10:00 AM, at 12:04 PM On , no ESS data entry was made for that day On , the ESS data entry was made after 10:00 AM, at 11:35 AM On , no ESS data entry was made for that day On , the ESS data entry was made after 10:00 AM, at 12:20 PM On , no ESS data entry was made for that day On , the ESS data entry was made after 10:00 AM, at 10:43 AM On , no ESS data entry was made for that day On , no ESS data ESS data entry was made for that day On , no ESS data entry was made for that day On , no ESS data entry was made for that day On , the ESS data entry was made after 10:00 AM, at 11:12 AM On , the ESS data entry was made after 10:00 AM, at 10:37 AM On , the ESS data entry was made after 10:00 AM, at 10:47 AM On , the ESS data entry was made after 10:00 AM, at 10:22 AM On , the ESS data entry was made after 10:00 AM, at 11:20 AM On , no ESS data entry was made for that day On , no ESS data entry was made for	CZ830		

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CZ830	Continued From page 4 that day On , no ESS data entry was made for that day On , the ESS data entry was made after 10:00 AM, at 11:45 AM On , the ESS data entry was made after 10:00 AM, at 12:48 PM On , no ESS data entry was made for that day Over 90 days, the facility failed to enter the required daily ESS data for 15 days, and failed to enter the required daily data by 10:15 AM for 17 days. This was discussed in a telephone interview conducted with the Administrator and the Manager on at 2:56 PM. They acknowledged the ESS data is required to be entered into the Agency's online ESS database daily by 10:00 AM.	CZ830		