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 _____	R 06/10/2021

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

(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 revisit to licensure complaint (#2020016611) survey was conducted on [redacted] at Savorah ALF II LLC. The facility had an uncorrected deficiency 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}		

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 _____	R 06/10/2021

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

(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 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}		

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 _____	R 06/10/2021

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

(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 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

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 _____	R 06/10/2021

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

(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 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 interview and record review, the facility failed to assess 1 out of 3 residents (resident #1)	{A 010}		

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 _____	R 06/10/2021

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

(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 010}	Continued From page 4	{A 010}		

for continued appropriateness of residency after the resident's recent elopements and refusal to receive medical care which interfered with the facility's ability to provide necessary supervision, care and services.

The findings included:

Review of resident #1's record indicated that the resident was admitted to the facility on . Review of the resident's health assessment dated on indicated, that she was diagnosed with , high , , and , . Review of this health assessment indicated that the resident was independent with all of her activities of daily living and required daily oversight of her whereabouts and with her wellbeing. Review of this resident's record indicated that there were no other recent health assessments or elopement-specific evaluations to determine the resident's current physical, behavioral and mental health status.

Review of the police report [XXX] indicated that Resident #1 had eloped from the facility on at approximately 8:00pm. Review of this report indicated that the resident had , did not have a cell phone on her person and had a history of elopements from the facility. Further review of this report indicated that the resident was likely heading towards Hutchinson Island and that since the police air search unit was not available, the police will respond to search for the resident with a drone and canine unit.

Review of Resident #1's progress notes dated on indicated that the resident went missing after the staff passed out snacks to the facility residents at around 8:00pm. Review of the

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 _____	R 06/10/2021

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

(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 010}	Continued From page 5	{A 010}		

progress notes dated on indicated that the police notified the facility that resident #1 was found around 11:30am in the city of Stuart and was brought to the facility. Review of a vicinity map of the facility, it indicated that the city of Stuart was approximately 8 miles away from the facility.

Review of the police report indicated that on at 6:18pm, the Administrator stated that Resident #1 had eloped from the facility again, was missing for about an hour and a half and she did not know where the resident was at. Review of this report indicated that the Administrator stated that the resident went missing after the resident had been outside the facility smoking a cigarette and didn't come inside the facility. Review of this report indicated that the resident refused medical care from any physician and also refused to take any prescribed medications. Further review of this report indicated that the police searched for the resident with its patrol and canine units at that time.

Review of Resident #1's progress notes dated on indicated that the resident went missing after being seen smoking outside of the facility by a staff member at around 9:35am. Review of the progress notes indicated that the resident could not be found and the police was called to report this resident leaving the facility without knowledge of her whereabouts. Further review of the progress notes indicated that the resident was found "down the street" by the supervisor and brought to the facility.

Review of the facility elopement policies and procedures dated in , it indicated that it was the facility's priority to foster an environment of safety and good quality of life for

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 _____	R 06/10/2021

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

(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 010}	Continued From page 6	{A 010}		

all residents, and to establish a sign out/sign in log to determine each resident's whereabouts and facilitate locating a resident during a temporary absence. Review of these policies and procedures indicated that an elopement was meant whenever a resident left the facility without following the policies and procedures. Further review of these policies and procedures indicated that each resident must be evaluated for elopement risk before admission to the facility and whenever a resident's elopement risk is identified after admission, this must be documented in each resident's record.

In an observation on at 1:45pm, the facility did not have a resident sign out/sign in log anywhere in the common areas so the residents may use this log to follow policies and procedures during temporary absences. In an interview with the administrator on at 1:50pm, she stated that she did not have a resident sign out/sign in log for residents' use during their temporary absences.

In an interview with Resident #1 on at 2:00pm, she stated that she did not like living in the facility because she preferred to live in her own home. She gestured at this time, that she did not want to further talk about her current living situation in the facility.

In an interview with the Administrator on at 2:45pm, she stated that Resident #1 had and continually refused medical care. She stated that the resident refused to bee seen by the physician extender last month, by the resident going into her bedroom and locking the door whenever the physician extender asked the resident if she wanted to receive a medical examination. She stated that the resident also

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 _____	R 06/10/2021

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

(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 010}	Continued From page 7	{A 010}		

declined to take all of her previously prescribed medications since about the year 2018. She stated that not knowing the resident's most current medical status further complicated the facility's ability to deliver care and services to the resident.

In an interview with the Administrator on at 3:55pm, she stated that Resident #1 never received an elopement-specific evaluation from the facility to determine the resident's elopement risk. She stated that this resident was indeed an elopement risk and that the facility did not usually admit residents with exit-seeking behaviors or elopement tendencies. She stated that the resident recently eloped from the facility at least 3 times since and that she intended to help the resident find a facility which could prevent future elopements and to receive medical care. She also stated that since the resident did not presently have an identification card or a cellular telephone on her person, she will provide these items to the resident to prevent future elopements from the facility.

In an interview with Resident #1's daughter on at 5:05pm, she stated that she was aware that Resident #1 recently eloped from the facility on 2 different occasions, but she was not aware that the resident eloped from the facility on . She stated that she was also aware that whenever the resident eloped from the facility, the resident was placed in harm's way and was at risk for an accident. She stated that she was aware that the resident's lack of having received recent medical care and her continued exit-seeking behavior, the facility was required to ensure the resident's overall health, safety and wellbeing. She stated that since she lived out of the State of Florida, she relied on the

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 _____	R 06/10/2021

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

(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 010}	Continued From page 8 administrator to gather any available resources needed so she may make a decision to move the resident to another facility which could promote medical care and prevent future elopements for the resident. The Administrator was unable to provide any evidence indicating the resident had been reassessed by his/her physician due to the signfiicant health and behavioral changes. The facility was also unable to provide documentation indicating the facility had evaluated and assessed the resident's current needs to determine if the resident met the criteria for continued residency. Class III Uncorrected	{A 010}		