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
	AL11966519	A. BUILDING: _____ B. WING _____	06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF MAITLAND	740 NORTH WYMORE ROAD MAITLAND, FL 32751

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A 000	Initial Comments An unannounced complaint investigation, 2022008874, and change of ownership, was conducted at Ambiance of Maitland Assisted Living Facility, on [redacted]. Deficient practices were found at the time of the surveyor visit. CHOW	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making [redacted] for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. 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,	A 025		

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A 025	Continued From page 1 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. (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 the facility's documentation, observation, resident record review and interview, the facility failed to maintain the general whereabouts of 1 of 3 sampled residents (#10) that eloped from the secured Memory Care unit. Findings: An agency report dated . . . . . at 8:05 PM, documented that resident #10 eloped from the secured Memory Care unit. He was last seen in the unit at 7:50 PM near the TV common area by	A 025		

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A 025	Continued From page 2 Med Tech G. Med Tech G was making her rounds with the medication pass and got to (resident #9) and saw that the window was removed from the frame laying on the bed side table. Med Tech G alerted the other staff and her supervisor the Memory Care nurse I, that resident #10 was missing from the facility. On at 8:19 PM, caregiver F drove in her car and found resident #10 at the adjacent neighborhood about 250 away, resident #10 had made it to the neighborhood's security gate. Resident #10 had been missing from the Memory Care unit for 14 minutes total. He had no injuries. Observation on at 9:45 AM, there was nails put into each Memory Care window unit by the Administrator. An interview with the Administrator at 11 AM, confirmed that he put the nails in all the memory care windows as a temporary fix until the facility finished renovations. Resident #10's record review revealed an admission date of . The last 1823 Health Assessment dated documented that resident #10 was an elopement risk. The admission 1823 Health Assessment dated /2021documented the resident was an elopement risk as well. His medical conditions listed were , lower extremity , and . He needs assistance with activities of daily living (ADLs) that include bathing, , and grooming. He needs supervision with ambulation, toileting and transferring. The resident is independent with eating. (Photographic Evidence Obtained)	A 025		

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A 025	Continued From page 3 On , a physician order for resident #10, documented that a analysis was to be completed due to change in behavior. There was a warning on that there were some behavior changes from resident #10, twelve days (12) before the elopement occurred and the facility did not put additional supervision in place. On at 1:30 PM, an interview with Memory Care nurse I understood and confirmed the findings. Class II	A 025		
A 032 SS=D	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response	A 032		

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A 032	Continued From page 4	A 032		

policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.
2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.
(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:
1. An immediate search of the facility and premises,
2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,
3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and,
4. The continued care of all residents within the facility in the event of an elopement.
(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement

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A 032	Continued From page 5 drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on resident record review, facility's documentation and interview, the facility failed to ensure that a required daily effort was made to ensure identification (ID) was on their persons for 2 of 3 sampled residents (#10 & #12) that were identified as at risk for elopement. Findings: 1. Resident #10's record review revealed an admission date of [redacted]. The last 1823 Health Assessment dated [redacted] documented that resident #10 was an elopement risk. The resident was listed on the admission 1823 Health Assessment dated [redacted] as an elopement as well. His medical conditions listed were [redacted], lower extremity [redacted], and [redacted]. He needs assistance with activities of daily living (ADLs) which include bathing, [redacted], and grooming. He needs supervision with ambulation, toileting and transferring. The resident is independent with eating. 2. Resident #12's record review revealed an admission date of [redacted]. The last 1823 Health Assessment dated [redacted] documented that resident #12 was an elopement risk. Her medical conditions listed were [redacted], [redacted] and [redacted]. She needs assistance with activities of daily living (ADLs) which include bathing, [redacted], and grooming. She needs supervision with transferring. The resident is independent with eating, ambulation, and toileting. Further review revealed documentation that resident #12 was exit seeking	A 032		

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A 032	Continued From page 6 and had . . . . . and agitation. On ..... at 1 PM, review of the facility's elopement policies and procedures and noted there was a missing component to the policies and procedures that the facility at a minimum daily check for identification on their persons for residents assessed to be at risk elopement containing information of the name of resident, the facility's name, the facility's address, and the facility's telephone number. The facility must be aware of the location of all residents assessed at high risk for elopement at all times. (Photographic Evidence Obtained) On ..... at 1:30 PM, an interview with Memory Care nurse who confirmed the findings. Class III	A 032		
A 093 SS=D	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New	A 093		

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A 093	Continued From page 7 %20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet. 1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. 2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as	A 093		

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A 093	Continued From page 8 served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months. (e) Therapeutic diets must be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility. 2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal. (f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on	A 093		

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A 093	Continued From page 9 at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to keep 6 months of regular and therapeutic menus on file in the facility. Findings: Review of facility menus revealed no dated menus on file since the change of ownership on . On at 4:42pm during an interview, staff L confirmed the facility had not kept dated menus on file in the facility since the change of ownership on . Class III	A 093		
A 152 SS=D	59A-36.014(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to section 429.28(1)(a), F.S.; 2. Be maintained free of hazards; and, 3. Ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good	A 152		

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A 152	Continued From page 10 working order. (b) Pursuant to section 429.27, F.S., residents must be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident bedroom or sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress at a comfortable [redacted] to ensure easy access by the resident, 2. A closet or wardrobe space for hanging clothes, 3. A dresser, [redacted] or other furniture designed for storage of clothing or personal effects, 4. A table or nightstand, bedside lamp or floor lamp, and waste basket; and, 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident bedrooms to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility must be free of tears, stains and must not be [redacted]. This Statute or Rule is not met as evidenced by: Based on observation and interviews, the facility placed the resident community, 68 residents, at-risk by failing to maintain carpet in both the Assisted Living Facility and Memory Care Unit. Findings: On [redacted], while touring the Assisted Living Facility, at 8:55 AM, it was observed that the	A 152		

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A 152	Continued From page 11 carpet on the second was heavily stained and worn. (Photographic evidence obtained). On , at 9:05 AM, the administrator, when asked about the carpeting, stated the facility was in the process of changing the carpet for new carpeting. Observation on at 9:45 AM, the carpet located in the secured Memory Care unit especially near the TV common area and the dining room was very dirty and stained with black, brown, and orange-like substances. (Photographic Evidence Obtained) On at 10 AM, an interview with the Administrator confirmed the findings. He further stated that the carpet will be totally replaced with tile once the renovations are completed in the facility. Class III	A 152		
CZ830 SS=D	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	CZ830		

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CZ830	Continued From page 12 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 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	CZ830		

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CZ830	Continued From page 13 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) . . . Licensees 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 record review and interview, the facility placed the resident community, 68 residents, at-risk by failing to maintain an approved CEMP from the local emergency office. Findings: On , the Agency requested a copy of	CZ830		

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
	AL11966519	A. BUILDING: _____ B. WING _____	06/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH GRAND OF MAITLAND	740 NORTH WYMORE ROAD 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
CZ830	Continued From page 14 the current CEMP letter for review during the change of ownership survey. On , at 11:50 AM, in an interview with the administrator, he stated he was not able to provide a copy of the current CEMP letter. He stated the letter on file expired on and a new plan was not submitted because the facility is going to change generators. Class III	CZ830		