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
	AL11964702	A. BUILDING: _____ B. WING _____	R 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF ORANGE CITY	202 STRAWBERRY OAKS DRIVE ORANGE CITY, FL 32763

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{A 000}	Initial Comments A second revisit to a relicensure survey was conducted at Savannah Court of Orange City on . Deficiencies were identified.	{A 000}		
A 054	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 offered or administered and include: 1. The name of the resident and any known 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 , 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.	A 054		

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A 054	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on a review of resident records and interviews with staff, the facility failed to maintain complete and accurate medication observation records (MORs) and immediate update the record each time the medication was offered, for 3 of 5 residents whose medications were reviewed (Residents 1, 2 and 5). The findings include: An interview was conducted with Employee A, Medication Technician (MT) on [redacted] at 10:05 am. She stated she had been a MT since 2008, and had received training on assisting residents with medications. Part of that training included reviewing and signing the MORs. She was also trained that if a medication was not available, to re-order it, contact the nurse, and sign and circle it on the MOR. Then note the medication name, time, reason not given and if the physician and pharmacy were contacted on the record. A medication reconciliation was conducted on [redacted] at 11:35 am with Employee A, in the presence of the Resident Care Coordinator (RCC). Record review for Resident 1 revealed she had physician's orders for [redacted] (treats high [redacted]) 5 milligrams (mg) every night at bedtime (8:00 pm). Review of Resident 1's Medication Observation Records (MORs) for [redacted] found multiple doses of [redacted], including the [redacted] and [redacted] doses, were initialed with a circle drawn around the initials indicating the medication was not taken. There were no explanations on the [redacted] of the MOR explaining any of the omissions. Photographic evidence was obtained.	A 054		

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A 054	Continued From page 2 Medication reconciliation for Resident 5 found she had physician's orders for Flecanide (treats/prevents irregular heartbeats) 50 mg twice daily. Review of the , MOR found the morning dose of this medication was not signed out from to . All signature boxes were blank, with no explanatory notes on the MOR. Photographic evidence was obtained. Review of Resident 2's medication orders and MOR found she had an order , ... (a , medication) 7.5/325 mg three times a day. There were missing signatures for two scheduled doses in , , but no written explanation. An interview was conducted with the Resident Care Coordinator (RCC) at this time. She stated the Medication Technicians should be comparing the MORs against the medications before giving them and should be signing off on all medications given. She said she checked the MORs almost daily, but missed that Resident 5's Flecanide was not signed off since . . . . . The RCC explained Resident 1's was being delivered tonight, but she could not provide evidence of when the last pill was given. She said the circled initials for that medication was when the resident was on leave with family. The RCC confirmed there were no notes related to the circled initials. She had no explanation why the MORs were not noted to explain other omissions. The Administrator was interviewed on . . . . . at 12:05 pm. She acknowledged there was no system to track medication orders and that it was not possible to determine when Resident 1's . . . . . ran out. The Administrator also acknowledged the concern over lack of documentation to explain if medications were on order, deliberately held or if the resident was on	A 054		

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A 054	Continued From page 3 leave at the scheduled medication times. Class III	A 054		
A 078	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 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	A 078		

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A 078	Continued From page 4 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 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 observations and resident and staff interviews, the facility failed to ensure qualified staff were available for 1 of 5 residents (Resident 1) sampled. Resident 1 required medication administration from a licensed professional. The findings include:	A 078		

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A 078	Continued From page 5 An interview was conducted with Resident 1 on ..... at 9:15 am. She stated she was doing well but she has , ( ) and shook a lot. When asked how staff assisted with her medications, and if they provided over/under . . assistance for her to take them, she said no. Resident 1 explained she shakes too badly, so staff had to place medications directly into her . They have to pour the water into her . . . as well. Employee B, Medication Technician (MT), was interviewed on at 9:40 am. She reported Resident 1 shook, but she still puts her pills in a cup. They fly out when she assists this resident, so she has to hold Resident 1's . . . Once the cup of pills was put in her , Resident 1 can finally get it into her . . with . . over . . assistance. Employee B knew they could not put medications in the Resident 1's . . . . The staff were trained to put the cup in Resident 1's and make sure she did it herself. An interview with Employee A, MT, on ..... at 10:05 am, revealed she had received training on assisting residents with medications and the proper way to assist them. When she started working here she recognized Resident 1 required a little more assistance with her medications. Employee A said she provided . . . over . . assistance with her medications and encouraged Resident 1 to just "calm down, breathe, and take her time" during the process. Employee A said she reassures Resident 1 when she got . . . or shook. Employee A, MT, demonstrated the provision of assistance with self-administration with Resident 1 on at 10:15 am by using an empty	A 078		

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A 078	Continued From page 6 plastic medication cup and a cup of water. She placed the small medication cup into Resident 1's right and attempted to provide -under- assistance for Resident 1 to lift the cup to her . Resident 1's shook and jerked violently under the effort. Despite using significant force, Employee A could only get the cup to for Resident 1. By this time, the cup was sideways and wouldn't have held any medications. Employee A was unsuccessful in getting the cup to a position that would deliver medications to Resident 1's , despite her encouragement. She switched and repeated the same process with Resident 1's left ; however, the resident shook and jerked so violently there was no chance any pills would have remained in the cup long enough to get them to her . Employee A then attempted to have Resident 1 demonstrate that she could drink on her own. Resident 1 jerked through her efforts, spilling the cup of water all over her shirt. In a second interview with Resident 1 on at 10:40 am, she again insisted staff had to place her pills into her . She could not successfully get her medicine to her , even with assistance. Employee B, MT, was interviewed on at 10:45 am. She again confirmed it was very difficult to get medications to Resident 1's and said the pills often spill out. She has to pick them up and put them in the cup and keep trying. An interview was conducted with the Administrator in the presence of the Resident Care Coordinator (RCC) on at 12:40 pm. They were advised of the interviews and observation with Resident 1. The Administrator	A 078		

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A 078	Continued From page 7 stated that while they had provided training, she has not been in the room to watch staff assist Resident 1. She acknowledged the difficulty Resident 1 had due to her forceful involuntary jerking. She also acknowledged the experience might be , due to the level of physical force staff must use while assisting. The RCC reported she watched once at the dining table, and the MT was able to provide successful assistance to Resident 1, but she had not watched since. The Administrator said she believed she needed a nurse to do the medications for Resident 1. Class III	A 078		