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
	AL11965546	A. BUILDING: _____ B. WING _____	C 06/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF BARTOW	290 IDLEWOOD AVENUE BARTOW, FL 33830

(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 complaint (complaint number 2023009331) was conducted at Savannah Court Of Bartow on . The facility had deficiencies at the time of survey.	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 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 must notify the resident's representative or designee of the need for health care services and must assist in making 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, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

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

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A 025	Continued From page 1 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 observation, record review and interview the facility failed to provide appropriate supervision and monitoring for safe smoking practices for 1 (Resident #1) of 3 sampled residents that smoke, resulting in Resident #1 clothing catching fire producing . . . to 30 percent of Resident #1's body. Findings included: A record review of the facility's self-reported incident conducted on . . . . . dated . . . . . revealed Resident #1 was in the courtyard smoking a cigarette when they became ingulfed in flames. Resident was transported to a	A 025		

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A 025	Continued From page 2 local hospital via emergency management services on . A record review was conducted on of a local hospital report for Resident #1 dated revealed Resident #1 was admitted to the hospital for . . to 30 percent of their body on . A record review of Resident #1 medical file was conducted on revealing Resident #1 has a history of , and is independent with eating and ambulation needs supervision with transferring and needs assistance with bathing, , self-care and toileting. The medical file reviewed was dated . An interview was conducted with the Administrator on at 10:10a.m., he stated Resident #1 was in the designated smoking area on in the morning and their clothing had caught on fire resulting in Resident #1 being taken to a local hospital for . . to their body. An interview was conducted with Resident #5 on at 9:32a.m. and stated that staff did not assist them when smoking in the designated area. An interview was conducted on at 3:20p.m. with a Health Care Provider who stated he was in a resident's room when he heard someone in the courtyard yell fire. He stated he immediately went to the resident that was on fire, removed his shirt and used the resident's shirt to extinguished Resident #1. The Health Care Provider also stated he did not observe staff monitoring residents smoke other than looking	A 025		

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A 025	Continued From page 3 out the windows when residents were smoking. An interview was conducted with the Health and Wellness Director on at 10:22a.m. which revealed the facility did not have policy regarding staff checking on residents while smoking. An interview was conducted with the Health and Wellness Director on at 10:40a.m. which revealed the facility had not conducted any type of smoking assessments for any residents. An observation was conducted on at 11:30a.m. of the designated smoking area which revealed no type of fire blanket or a fire extinguisher. Class II	A 025		