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
	AL11953284	A. BUILDING: _____ B. WING _____	R 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF MAITLAND	1301 W. MAITLAND BLVD 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
{A 000}	Initial Comments A revisit to the re-licensure survey and complaint investigation #2024002283 was conducted at Savannah Court of Maitland on . The facility had an uncorrected deficiency at the time of the visit.	{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	{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 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 record reviews and interviews, the facility failed to provide adequate supervision to 1 of 1 sampled resident who eloped from the facility by maintaining a general awareness of the resident whereabouts and to ensure safety through proactive measures to minimize the potential for . . and injuries (#5). Findings: On . . . . . at 9:25am during the entrance conference, the Administrator stated Resident #5 was out of the facility due to a . and was in rehab.	{A 025}		

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{A 025}	Continued From page 2 A record review of Resident #5 revealed a facility's admission on [redacted]. A [redacted] Health Assessment Form (1823) indicated a medical history of [redacted], mild [redacted], history of [redacted] (DN), [redacted], low [redacted] (LBP), and was identified as a [redacted] risk. The resident was not identified as an elopement risk. A review of an incident report dated [redacted] stated the outcome of the incident as resident elopement. The resident exited the building through the front door at approximately 2:00pm, as she was outside for activities. The resident was last seen sitting on a bench outside the front of the building at approximately 3:30pm. At approximately 4:51pm, Unlicensed care staff A initiated a "Code Purple" alert, as she and other staff members searched the community and Resident #5 was found in the grass near the [redacted] of the building." A facility note on [redacted] at 4:50pm read, "per med tech unlicensed care staff A went to resident room to escort her to dinner, resident not in her room. Unlicensed care staff A went to dining room and resident not in dining room. Code Purple initiated. Residents found on [redacted] of building on the floor between the bushes, no loc (level of care) noted at this time. 911 was called, arrived at the scene, and branches were cut to get resident. The resident was placed on a stretcher and transferred to Advent Health (A.H.S). Further review of Resident #5's Progress Notes did not reveal any additional documentation after the date of the incident. The facility's undated Elopement/Missing	{A 025}		

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{A 025}	Continued From page 3 Resident Policy states, "when a resident leaves the facility property beyond the perimeter of the parking lot or further and is missing for hours or more, without the facility's knowledge, and who have not signed out nor verbally informed the facility of their plans for returning or a resident who cannot be located in the customary areas within the facility by the staff. On at 2:05pm Unlicensed care staff A stated, "I arrived at work and started doing my rounds. I work 2nd shift 3 -11. By me knowing Resident #5 she usually . . . . . over to the Cove inside of the building and I have to go get her. After checking her room and she was not there. I stopped by at the front desk to ask if they had seen her. The front desk stated she asked them to help her transfer money to her Walmart card to get some things. I knew that was not normal. So, to me that meant she was trying to go outside. I then asked Unlicensed care staff C if she saw Resident #5 when she came in. She stated she saw her sitting outside on the porch. I then checked inside the facility to make sure she was not in her room, the bathroom, or any other areas that she likes to go to. After I couldn't find her, I called a code purple, told Nurse B and went outside while everyone looked again inside calling another code purple. I found Resident #5 outside behind the building. She had in some bushes. She was alert but didn't know what happened when I asked her. She said she didn't remember how she got . . . there. I did an assessment without moving her. When I touched her, I knew something was wrong. I called Nurse B while staying with her. The nurse came, assessed her, and called 911. 911 arrived and they had to cut down some trees before she could be removed. The way she in the bushes they were not able to pull her out. Afterwards, she	{A 025}		

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{A 025}	Continued From page 4 was taken to the hospital and has not returned." On . . . . . at 2:44pm Nurse B stated, "One of the staff, I believe Unlicensed care staff C saw Resident #5 when she was coming in to work sitting outside. Then Unlicensed care staff A went to look for her for dinner and couldn't find her. After we looked for her inside, we looked outside, and found her in the bushes. We couldn't pull her out, so we called 911 for assistance. I proceeded to ask Nurse B if she had any additional notes for Resident #5's incident or discharge from the hospital. She stated that's all the notes we have (referring to the progress notes). That's the only note that I did for that event. I'll talk to the Resident Care Director for information from the hospital and rehab. I did the incident report and it's a paper report. I'll bring that for you to review." On at approximately 3:00pm the Regional Care Director provided Resident #5's Incident Report dated . A review of the Incident Report Form dated . . . . . , time 4:50pm read, Per Unlicensed care staff A resident not in her room, not in dining room. Code purple activated. Resident found on of building between the bushes. . . . . Right . . . . and left . . . . Resident , 911 called." On at 3:19pm Unlicensed care staff C was contacted via phone and a voice message was left for a call . The Administrator was asked regarding Resident #5's elopement and to be escorted to the path of the incident. The Administrator was also asked for any additional notes of the resident's discharge from the hospital to the rehab.	{A 025}		

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{A 025}	Continued From page 5 On at 4:00pm a copy of Resident #5's move in assessment was requested. On at 4:10pm the Regional Care Director stated Resident #5 does not have an assessment after reviewing her chart to determine it was not included under the assessment tab. On at 4:10pm the Administrator stated, "Oh, I was not here when that happened and only heard about it (referring to Resident #5's elopement). The Resident Care Director was, and I'll have her to show you. I'll go check to see if there are any additional notes, but the resident went to Life Care Center of Altamonte Springs. She's in a secured unit there for rehabilitation." On at 4:20pm the Resident Care Director stated, "I was not here as well that day but received the phone call of the incident. However, I can show you the path but I'm not sure of the exact location of where she was found. The Resident went out the front door and to the left of the parking lot. She was still on the property of the facility but did not inform the staff at the front desk she was leaving. The Resident Care Director stated, I will call Unlicensed care staff A to come out and show you where Resident #5 was found. I do know they had to cut down some bushes due to the way she as they were unable to pull her out." Unlicensed care staff A arrived at the of the building and identified the location of the cut branches and bushes of Resident #5's . On at 4:20pm the Resident Care Director provided a Resident Functional Evaluation and Service Plan for Resident #5	{A 025}		

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{A 025}	Continued From page 6 dated . . . . indicating this was the assessment plan. A review of the plan indicated on page 4 of 6 Resident #5's score was 44 points which requires a Level III service care plan. The service plan provided was incomplete and did not list what was included in the level 3. Further review of the assessment did not include the breakdown as to the specific care requirements for level III. The . . . . . awareness score revealed a 3 which states minimum asst/forgetful, needs occasional reminders for meals and activities. The Administrator and Resident Care Director was asked for any additional notes on Resident #5 as the progress notes did not list any further documentation after the incident. On at 5:50pm the Administrator stated, "that's all we have. The Resident Care Director stated, "I have the follow up notes in my cell phone. No, I did not document it in the resident's chart. I put the information in the incident report that I sent to AHCA." On . . . . . at 6:00pm further review of Resident #5's incident report stated, after being transported to Advent Health, Resident #5 was diagnosed with a . . . . . , displaced . . . . . of the left 3rd and 4th . She is stable and currently admitted to Life Care Center Altamonte Springs Rehabilitation. (photographic evidence obtained) Class II	{A 025}		