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 |
|---|---|---|---|
| | AL11964808 | A. BUILDING: _____ B. WING _____ | 10/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SAVANNAH COTTAGE OF OVIEDO | 445 ALEXANDRIA BLVD. OVIEDO, FL 32765 |

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| A 000 | Initial Comments<br><br>Two complaint surveys (2024009953 and 2024010627) and generator monitoring were conducted on at Savannah Cottage of Oviedo. Deficiencies were found at the time of the visit. | A 000 | | |
| A 025 SS=G | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(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.<br><br>59A-36.007 Resident Care Standards.<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(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<br><br>resident diets in accordance with Rule 59A-36.012, F.A.C.<br>(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.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(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.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(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.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record reviews, observation and interviews, the facility failed to ensure the safety and awareness of 1 of 2 sampled residents (#1) to prevent elopement from occurring.<br><br>Findings:<br><br>In a record review of resident #1, it revealed an admission date of and a health assessment dated . Medical history of , poor orientation, and . Resident#1 required assistance with medications and assistance with daily living to include , eating self-care, toileting, and | A 025 | | |

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| A 025 | Continued From page 2<br><br>bathing. Resident #1 resides in the memory care unit and is listed on the health assessment before the incident as an elopement risk. Resident functional evaluation dated states the resident is noted for risk of elopement, , and attempted to elope in past.<br><br>Further review of the resident#1's record revealed the following facility progress notes:<br>3:45am residents noted not be in room, search conducted all areas. Searched community. 4:08am law enforcement called. At 4:40am a resident was located by law enforcement in the parking lot next door to the facility. The resident was transported to the hospital for evaluation, no injuries.<br><br>Investigation was conducted and findings found to be the resident was last seen in his room at 3:40am and noted not to be in his room at 3:50am. Resident presents as and some memory . Residents have no exit seeking behaviors prior to incident. Resident placed on 1:1 from through .<br><br>In a review of an incident report dated revealed the following:<br>at 3:40am the resident was last seen by staff. At 3:50am staff went to check on the resident and he was not in his room. Staff began to search the residents' room, common area and then outside the building. At 4am multiple staff joined to search inside and outside the facility. 4:08 am law enforcement was called. At 4:40am law enforcement found the resident at the adjacent parking lot to the facility approximately 500 from the facility. The resident was transported to the medical center for further evaluation. No injuries occurred. | A 025 | | |

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| A 025 | Continued From page 3<br><br>In a review of the facility's elopement policy, it states elopement is defined as when a resident leaves the facility property beyond the perimeter of the parking lot without facility knowledge and who have not signed out nor verbally informed the facility of their plans for returning.<br><br>In an observation of resident#1, on at 10am, the resident was sitting in the front area staring at the front doors and watching people come in and out. He was not supervised by any staff. He was not wearing any identification or any identification on his person.<br><br>In an interview on with caregiver A at 11am she stated resident #1 is always restless and has exit seeking behaviors. She stated he was moved from the assisted living side of the facility because of his behavior of wanting to leave. She stated the alarms on the exit doors are not loud enough if staff are busy attending to other residents in their rooms. She stated resident#1 went out the front door and the alarm went off but was not heard right away.<br><br>In an interview on at 12pm with the Wellness Director, stated the staff did not hear the alarm when resident #1 left out of the front doors. She stated since then they have put louder alarms on the doors so staff can hear if they go off.<br><br>at 12pm with resident #1's power of attorney, stated he was concerned about the incident as he thought the reason resident #1 was moved to the memory care unit was because he was at risk for elopement. He stated the services he is paying for in the memory care unit was to always monitor and supervise resident #1 and ensure he does not leave the facility without | A 025 | | |

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| A 025 | Continued From page 4<br><br>supervision. He stated the facility was aware that resident #1 had a history of risk for elopement, and it is also stated on his health assessment. He stated he was assured by administration and staff at the facility that resident#1 would not be unable to leave the facility unsupervised in the memory care unit.<br><br>In an interview on at 12:30pm with the Wellness Director, she confirmed the above findings.<br><br>Photographic evidence taken<br><br>Class II | A 025 | | |
| A 032 SS=D | 59A-36.007(7) FAC Resident Care - Elopement Standards<br><br>59A-36.007<br>(7) ELOPEMENT STANDARDS.<br>(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.<br>1. As part of its resident elopement response policies and procedures, the facility must make, | A 032 | | |

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| A 032 | Continued From page 5<br>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.<br>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.<br>(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:<br>1. An immediate search of the facility and premises,<br>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities,<br>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,<br>4. The continued care of all residents within the facility in the event of an elopement.<br>(c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. | A 032 | | |

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| A 032 | Continued From page 6<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure 2 of 2 sampled residents (#1 & #3) had identification on their person for person at risk for elopement.<br><br>Findings:<br><br>1. In a review of resident#1's record, it confirmed he eloped from the facility on and is noted on his health assessment as an elopement risk.<br><br>In an observation on of resident #1, he did not have identification with the facility's name, address and phone number. Resident #1's picture and information was not at the front desk as required after the resident is identified as an elopement risk.<br><br>2. In a review of resident #3's record, it confirmed her health assessment notes she is an elopement risk.<br><br>In an observation on of resident#3, she did not have identification on her with the facility's name, address and phone number. Resident #3's picture and information was not at the front desk as required after the resident is identified as an elopement risk.<br><br>In an interview on at 12pm with the wellness director, she confirmed the above findings and stated she was not aware that the elopement risk resident's need to have identification on them at all times.<br><br>Class III | A 032 | | |

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