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
	AL11964824	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVANNAH COURT OF OVIEDO II	395 ALAFAYA WOODS BLVD. OVIEDO, FL 32765

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A 000	Initial Comments A complaint investigation (2024014918) and generator monitoring were conducted at Savannah Court of Oviedo II on . The facility had deficiencies at the time of the survey.	A 000		
A 010 SS=D	429.26( ) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 Appropriateness of placements; examinations of residents.- (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must be based upon an evaluation of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility: (a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party. (b) A facility may admit or retain a resident who requires the use of assistive devices. (c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician	A 010		

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A 010	Continued From page 1 who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care. (d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to: a. Move, turn, or reposition without total physical assistance; b. Transfer to a chair or wheelchair without total physical assistance; or c. Sit safely in a chair or wheelchair without personal assistance or a physical . 2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days. 3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days. (2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.	A 010		

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A 010	Continued From page 2 (3) A physician, physician assistant, or advanced practice registered nurse who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests in the facility. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a -to- medical examination by a health care practitioner at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 59A-36.002, F.A.C. The results of the examination must be recorded on the practitioner's form or on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days, unless the resident is receiving licensed hospice services pursuant to Section 429.26(1)(c), F.S. (b) A resident requiring care of a , may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care practitioner, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within	A 010		

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A 010	Continued From page 3 30 days, as documented by a health care practitioner, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements an interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility retained 1 of 2 sampled residents (#5) who was no longer appropriate for continued residency. Findings: The facility held only a standard license. Review of resident #5's record revealed a facility admission date of . A health assessment form (1823) indicated the resident had , , , he needed total assistance with bathing, , toileting, ambulation and transferring and assistance with grooming. On the resident was admitted to the facility with a , , under him. He needed five people to transfer him to bed. A 1823 indicated the resident had , , , needed only assistance with bathing, , grooming, toileting, ambulation and transferring and was bedridden. On the resident was admitted to hospice services. On at 10:09 am, nurse A said resident #5 was both bedridden and needed total assistance with transferring. The nurse said the resident used to be on hospice but was discharged from services. On at 10:10 am, resident #5 was awake and laying in a hospital bed. He said he did not	A 010		

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A 010	Continued From page 5 get out of bed because "my ⌄ don't work at all. They don't have a hoist to put me in the wheelchair." He said he was bedridden since his admission to the facility. He confirmed he was discharged from hospice. On at 11:30 am, resident #5 said he used the side rails on his bed to exercise and roll side to side. He said staff changed his brief four times each day then repositioned him. He said he was able to wash his , perform his own oral care and wash his upper body. The resident's record did not have documentation to indicate when he was discharged from hospice. On at 12:31 pm, nurse A said the resident was discharged from hospice on . On at 12:48 pm, caregiver B said the resident had always been bedridden because he was paralyzed in his lower body. The caregiver said the resident needed total assistance for lower body ⌄ and toileting. The resident had a , . Nurse A was present during the interview and agreed with caregiver B's assessment of the resident's care needs. On at 1:56 pm, the administrator said the resident was able to get out of bed, but he chose not to. The administrator said the facility took no steps to discharge the resident when he was discharged from hospice and no longer met the criteria for continued residency. Class III	A 010		

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A 025	Continued From page 6	A 025		
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 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.	A 025		

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A 025	Continued From page 7 (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 review and interview, the facility failed to follow its policy, failed to document a , failed to notify the responsible party and a health care provider of the and failed to document the circumstances that led to a hospital transfer for 1 of 4 sampled residents who sustained multiple (#1.) Findings: A review of resident #1's health assessment form (1823) revealed the resident needed assistance with transferring. On the resident was sent to a hospital due to low level. On the resident returned from the hospital. She had no strength in her and	A 025		

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A 025	Continued From page 8 On a health care provider documented the resident was status post hospital stay for acute hypoxemia , failure, ( ) exacerbation and , secondary to a . The resident was now on continuous at 3 liters per minute. The resident reported lower extremity , "pins and needles" and had not gotten out of bed that and the previous day. The resident was very and uncomfortable with care due to the . On a health care provider ordered physical and occupational therapies for and transfers. On nurse A documented the resident was sent to a hospital. There was no documentation to indicate why. An hospital history and physical indicated the resident reported that on she slipped out of bed and a caregiver on top of her. The resident had to her right , since. An hospital computed scan ( ) revealed the resident had acute right and left and acute right . On at 12:30 pm, nurse A said she was unaware of the resident having a or other injury since the resident returned from the hospital on . The nurse said that although she wrote the note she was not working on that day, so she did not know why the resident went to a hospital. On at 12:40 pm, caregiver B said when	A 025		

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A 025	Continued From page 9 she checked on the resident on the morning of , she saw ⌄ and felt hardness from the resident's left waist down to her upper ⌄ . The caregiver said the resident was since her return to the facility on but the hardened area was different. She said the resident always complained of , all over her body. She said the resident was never able to stand and transfer. She said the resident always required two people to transfer her by lifting under each arm then pulling up on the of the resident's pants. The caregiver was unaware of any injury or . Nurse A was present and agreed with the caregiver's description of how much assistance was needed during transfers. On at 1:07 pm, nurse C said that on caregiver B asked her to come see the resident. Nurse C said the resident was in bed when she arrived. The nurse saw the resident's left , was but not red or warm to touch. The nurse said the resident did not complain of , and the nurse did not see rotation of the ⌄. When asked why she did not document her findings, the nurse replied, "because it was just and not like oh my god, there's something there." The nurse said the resident denied falling. On at 1:42 pm, the administrator said the resident could not bear a lot of ⌄ and , , was treating her for strength building. The administrator said the resident did not have a or injury prior to . On at 1:51 pm, the administrator said she did not know what the hospital diagnosed the resident with for the visit. She also did not know why the resident did not return to the facility. She did not speak with the resident's family until they picked up the resident's	A 025		

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A 025	Continued From page 10 belongings after the resident , . On at 2:20 pm, caregiver D said that one morning sometime after the resident returned from the hospital on , she cleaned the resident then while transferring the resident from bed to wheelchair, she could not lift the resident up high enough to sit on the wheelchair cushion, so she went to put the resident in bed when the resident began sliding down the caregiver's body. The caregiver then placed the resident in a laying position on the floor and got nurse A to come. The caregiver said the resident was never able to bear and always had to be transferred by lifting her under her arms. The caregiver said when the resident returned from the hospital on her were and way heavier. The caregiver said the resident complained of , in both even before the incident where she had to lay the resident on the floor. This incident was not documented in the resident's record. Nor was there documentation to indicate the resident's family and a health care provider were notified. On at 3:36 pm, nurse A confirmed caregiver D's statement but she could not remember the date it happened. The nurse confirmed she did not document the incident. She said caregiver D came to her and said she had to place the resident on the floor and that it was not a . The nurse arrived to see the resident lying on the floor. The nurse and the caregiver got the resident off the floor. The nurse said the resident's only complaint of , following the incident was her usual complaint of generalized body , . The facility's undated policy defined a as, among other things, "during staff transfer (a	A 025		

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A 025	Continued From page 11 occurring while staff is aiding in transferring a resident from one surface to another, such as a chair to bed transfer.)" The policy indicated that the health care provider and family should be notified and documented in the resident's record. A post- huddle should be conducted with the resident and any witnesses within a reasonable time frame and documented. A witness report should be completed for anyone who observed the . A supervisor will complete a resident investigation report to review the incident and analyze for root cause. On at 3:45 pm, the administrator said she did not know caregiver D had to lower the resident to the floor. A request was made of the administrator to provide any risk assessments for this resident and for the investigation report for the incident. On at 4 pm, the regional nurse provided a functional assessment and service plan and said this was the only one. She said a investigation report was not completed for the incident. The functional assessment indicated the resident needed - 2 person assistance/2 person transfer. On at 10:10 am, nurse C said that on she advised staff to send the resident to the hospital just to be on the safe side. Caregiver D was on the call and said when she lowered the resident to the floor, she did not on top of the resident, nor did she have to roll the resident off her. When asked why she did not have a second person with her to transfer the resident she replied that she never had a second person because she was always able to do it herself. The	A 025		

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A 025	Continued From page 12 caregiver said she did not get the resident out of bed anytime she worked after that. The administrator was on the call and said the resident was able to transfer with one assist and had only recently declined which is why she discussed with the family possibly transferring the resident to a rehabilitation facility, which did not occur. Class II	A 025		