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 _____	04/28/2025

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 (#2025004166) and a generator monitoring was completed on at Savannah Court and Cottage of Oviedo. A deficiency was 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 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, interviews and observations the facility failed to provide appropriate supervision that resulted in multiple and injury for 1 of 2 sampled residents (#1). Findings: In a review of resident#1's record confirmed an admission date of and a health assessment dated . The resident had a medical history of , , and hematoma. The resident was assessed to need precautions and precautions for , .	A 025		

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A 025	Continued From page 2 The resident needed assistance with ambulation, bathing, , eating, self-care, toileting, transferring and assistance with medication. The care plan dated revealed forgetfulness, no assistance with mobility, and with safety. The care plan was not updated to reflect . The resident , on due to medical history. In a review of the observation notes it revealed the following: 12am resident found on floor in room area noted on right side forehead resident had unwitnessed and hit of her ; emergency medical services were called. No injuries noted resident had an unwitnessed found on her , both blackened. Emergency services notified. Resident sustained from previous documented in an area unseen on prior . both appeared puffy. The resident was put on hospice care in hospital before returning to facility. The resident placed on crisis care for monitoring of . The resident passed while resting in bed. Review of the hospital notes dated revealed the resident has a history of ; she has had multiple . She was noted to be seen at the facility on where she was noted to have a subacute over the right side of her after a prior to that. This is the third in 2 weeks. There is soft tissue overlying the partially visualized region extending down the right .	A 025		

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A 025	Continued From page 3 There are calcifications involving the carotid bulb region. No acute are identified. There is suspected acute . There is appearing right sphenoidal and right ethmoidal . Interval development of hematoma over the , flax and left tentorium (10mm). Smaller hematoma over the left parietooccipital region (5-6mm). , hematomas. Review of the facility's policy dated 2017 states a is defined as any sudden uncontrolled unplanned downward movement of the body to the floor/ground or onto a lower surface with or without injury. Staff are responsible for identifying potential hazards to mitigate the risks. A risk assessment, residential functional evaluation and service plan (RFE) is utilized to assist in the development of a tailored service plan for each resident. When a resident is identified as a risk intervention aimed at mitigating risk factors should be reviewed and incorporated into the resident's RFE. Following any the residents should be assessed promptly. When an event is reported it is best to have them assessed before moving them. A post assessment and other documentation should be completed to thoroughly document the incident and response. An incident report should be documented. Possible interventions should be based on individual circumstances such as improving poor lighting, removing obstacles, reducing noise level, ensuring call light in reach, checking gait problems, providing supportive devices, , . During an interview on at 10:30 am staff A stated she has worked here for 9 months as an unlicensed staff. She stated resident #1	A 025		

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A 025	Continued From page 4 was a risk and she is not aware of any interventions for put in place. She stated she is aware of the policy to call the nurse or management when a occurs. She stated resident #1 was not here for a long time but a few times. She stated she was ambulatory and did not use a walker. During an interview on at 11am with the resident care coordinator, she stated resident#1 was not a risk when she first came here even though when she was admitted to this facility she had at a previous location where she was living. She stated the only care plan was at the time of admission and did not include as she was mobile. She stated after her admission she had a few and then spoke to the family about putting her on hospice. She stated after the last we sent her out to the hospital, and she stayed for one night before returning to the facility. She stated she incurred on her and a bump by her from the last and that is why we sent her to the hospital. She stated we did not make a new care plan or interventions after the she stated we put her on hospice instead. During an interview on at 11:30am with resident#1's family member, she stated resident#1 was found in the bathroom the last time she , and she was on her . She had a big by her . She started the resident was in her last stages of 's. She stated the first time she she was and then the second time she she hit her and was sent to the hospital. She stated she had racoon and shut. She stated as far as she knows there were no interventions put into place for . She stated she is not sure if the resident had a	A 025		

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A 025	Continued From page 5 before the or after. She stated the physician didn't know either. She stated resident #1 was only there for a couple of months so it is difficult to determine if the level of care was sufficient. She stated however they should have put some interventions in place to prevent her from falling. She stated the resident passed on from her medical condition as she was in the last stage of . In an interview on at 11:45 pm Staff B She stated she has worked in memory care for 3 years and resident#1 was a risk. She stated she is not aware of any interventions or care plan put in place to prevent resident #1 from . She stated she feels they could use more staff at night as there are only 2 staff on duty at a time, and the residents could use more care and attention. In an interview on at 12pm with staff D, she stated she has worked in memory care for 2 and ½ years. She stated resident#1 was a risk as she multiple times. She stated she was ambulatory without any adaptive equipment and would walk around all the time. She stated she is not aware of any interventions put in place for resident #1 to prevent her from falling. She stated she was verbal and could make her needs known. On at 12:30pm an observation was made of interactions with staff and residents. Residents were sitting in the dining area having lunch and staff were serving the meals. There were no obstructions in the common area or dining area. Residents appeared appropriately dressed for the weather. Photographic evidence was obtained	A 025		

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A 025	Continued From page 6 Class II	A 025		