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 07/09/2025

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 second revisit to a complaint investigation (2024016657) was conducted at Ansley Court. The facility had uncorrected deficiencies at the time of the visit.	{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 a resident who developed a , and no longer met the minimum requirement for continued residency for 1 of 7 sampled residents (11,) failed to ensure a health care practitioner conducted a -to- medical examination when 1 of 7 sampled residents (6) developed a , , and failed to ensure a licensed hospice, in consultation with the facility, developed and implemented an interdisciplinary care plan that specified the services being provided by hospice and those being provided by the facility for 1 of 7 sampled residents (6.) Findings: 1. Review of resident #5's record revealed a medical history of (.) She was dependent. On she was sent to a hospital for difficulty breathing and a low saturation. She was transferred to a rehabilitation facility following the hospital stay. On a care , group following her in the rehabilitation facility documented the resident had a , on her . On a nurse from the assisted living facility evaluated the resident while at the rehabilitation facility. The documentation of the evaluation indicated the resident's left had redness, a small center area red, no , no tissue necrosis, no or and no foul odor. The decision was that the resident could	{A 010}		

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{A 010}	Continued From page 5 return to the assisted living facility, which she did that same day. A health assessment form (1823) indicated the resident had , 3, or 4 , . Home health was ordered for care. On a health care provider ordered a hospital bed with half-side rails and air mattress due to having a , on the . On a home health nurse observed the had a large dark purplish-blue area of discoloration that blanched with fair , refill. On the measured 13 centimeters (cm) x 10 cm. On the measured 0.4 cm x 0.2 cm x 0.1 cm. On the measured 3 cm x 1.4 cm x 0.1 cm. Observation of the on at 3:50 PM revealed it measured approximately 3 cm x 2 cm x 0.1 cm. The bed was moist and pale pink in color. On at 5:50 PM, the administrator said she did not know the was described as in the rehabilitation facility. 2. Observation of resident #6's left on at 4:05 PM revealed the measured approximately 3 cm x 2 cm. The bed was moist and pink in color.	{A 010}		

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{A 010}	Continued From page 6	{A 010}		

Review of resident #6's record revealed a facility's admission on . A 1823 health assessment indicated nursing services, Vitas hospice and no indication of a , . .

A facility note on at 11:43 read, resident was seen by cornerstone nurse for admission. The resident is no longer with Vitas.

A facility note on at 14:35 read, writer notified staff that resident has an open area on her . The writer performed basic first aid to left . New order from a registered nurse practitioner (ARNP) or home health skilled nursing (HHSN) to treat and eval.

A facility note on at 10:42 read, resident is being discharged from Vitas hospice Services. The resident has declined and is needing hospice services, telephone order obtained to admit to Cornerstone Hospice.

The director of resident care was asked if resident #6 has a , was a care plan developed, and a new health assessment form was obtained for the new hospice services and change of condition.

On at 1:00 PM, the director of resident care stated, yes, resident #6 has a on her . When I looked at it last Wednesday to clean it. I discovered it was a stage. 2. Resident #6 is no longer with Vitas and now receives hospice services with Cornerstone.

On at 1:55 PM, the director of resident care stated that the former director of resident

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{A 010}	Continued From page 7 care put in orders, so Cornerstone is now treating her. I'll have to check for the care plan and notes from Cornerstone treating her . She continued by adding, the administrator stated a new 1823 was included as a part of the correction and included in resident #6's chart. On at 2:13 PM, the director of resident care stated, Cornerstone was here today to see resident #6 and I was able to get this information. No, I don't have the care plan. I'll have to call them to see if I can get a copy. Review of the Outside Agency Visit form dated by Cornerstone stated initial follow up visit treatment rendered: tiny red area between the . Clean it, no , apply mepilex. On at 3:31 PM, the director of resident care stated, Cornerstone will email a copy of resident #6's care plan to the administrator and the doctor coming tomorrow will provide a new 1823. The facility failed to obtain a new 1823 health assessment for resident #6's , new hospice admission and interdisciplinary care plan. Class III	{A 010}		
{A 056} SS=D	59A-36.008(7) FAC Medication - Labeling and Orders (7) MEDICATION LABELING AND ORDERS. (a) The facility may not store prescription drugs for self-administration, assistance with self-administration, or administration unless they are properly labeled and dispensed in	{A 056}		

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{A 056}	Continued From page 8	{A 056}		

accordance with Chapters 465 and 499, F.S., and Rule 64B16-28.108, F.A.C. If a customized patient medication package is prepared for a resident, and separated into individual medicinal drug containers, then the following information must be recorded on each individual container:
1. The resident's name; and,
2. The identification of each medicinal drug in the container.
(b) Except with respect to the use of pill organizers as described in subsection (2), no individual other than a pharmacist may transfer medications from one storage container to another.
(c) If the directions for use are "as needed" or "as directed," the health care provider must be contacted and requested to provide revised instructions. For an "as needed" prescription, the circumstances under which it would be appropriate for the resident to request the medication and any limitations must be specified; for example, "as needed for , , not to exceed 4 tablets per day." The revised instructions, including the date they were obtained from the health care provider and the signature of the staff who obtained them, must be noted in the medication record, or a revised label must be obtained from the pharmacist.
(d) Any change in directions for use of a medication that the facility is administering or providing assistance with self-administration must be accompanied by a written, faxes, or electronic copy of a medication order issued and signed by the resident's health care provider. The new directions must promptly be recorded in the resident's medication observation record. The facility may then obtain a revised label from the pharmacist or place an "alert" label on the medication container that directs staff to examine

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{A 056}	Continued From page 9 the revised directions for use in the medication observation record. (e) A nurse may take a medication order by telephone. Such order must be promptly documented in the resident's medication observation record. The facility must obtain a written medication order from the health care provider within 10 working days. A faxed or electronic copy of a signed order is acceptable. (f) The facility must make every reasonable effort to ensure that prescriptions for residents who receive assistance with self-administration of medication or medication administration are filled or refilled in a timely manner. (g) Pursuant to Section 465.0276(5), F.S., and Rule 61N-1.006, F.A.C., sample or complimentary prescription drugs that are dispensed by a health care provider, must be kept in their original manufacturer's packaging, which must include the practitioner's name, the resident's name for whom they were dispensed, and the date they were dispensed. If the sample or complimentary prescription drugs are not dispensed in the manufacturer's labeled package, they must be kept in a container that bears a label containing the following: 1. Practitioner's name, 2. Resident's name, 3. Date dispensed, 4. Name and strength of the drug, 5. Directions for use; and, 6. Expiration date. (h) Pursuant to Section 465.0276(2)(c), F.S., before dispensing any sample or complimentary prescription drug, the resident's health care provider must provide the resident with a written prescription, or a faxed or electronic copy of such order.	{A 056}		

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{A 056}	Continued From page 10 This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED Based on record review and interview, the facility failed to obtain a revised label from the pharmacy or place an "alert" label on the medication package to direct staff to examine the revised directions for use in the medication observation record (MOR) for 1 of 8 sampled residents (13) whose medication had a change in directions for use. Findings: Review of resident 13's medications revealed 12% lotion with prescription label directions to apply , , to arms and once a day. Review of the MOR revealed directions to apply , , to both lower extremities twice daily. No alert label observed on the medication bottle. On at 10:51am, unlicensed caregiver D, said she was not informed that the directions for the medication changed, the resident likes the medication to be applied to her only, and normally the medication order is transcribed to the MOR by the facility's pharmacy. Review of the resident's record revealed that on a health care provider ordered the medication to be applied , , to both lower extremities twice a day. On at 11:30am, the findings were discussed with the Resident Care Director, who said she has educated unlicensed caregiver, D about the importance of putting a direction change label on the medication and cannot just	{A 056}		

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{A 056}	Continued From page 11 scratch out the directions. Review of the facility's medication label policy revised , indicated a designated staff member flags the container with a brightly colored sticker and writes on it "order changed" with the date, time, and his/her initials. Class III	{A 056}		