STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964749	04/06/2017
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF OVIEDO I**	STREET ADDRESS, CITY, STATE, ZIP CODE **355 ALAFAY WOODS BLVD.** **OVIEDO, FL 32765**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

Complaint Investigation #2017000532 was conducted on . Savannah Court of Oviedo I, License #9235, had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on interview and record review, the facility failed to obtain an Completed Resident Health Assessment (AHCA form 1823) at admission and after a significant change (hospital admission) for 2 of 5 sampled residents (#1 & 2).

Findings:

1. Resident #1's Resident Health Assessment form (AHCA form 1823), dated , revealed that the type of assistance the resident required with medications was left blank, and noted she was a danger to herself.

Resident #1's facility's notes revealed she was admitted into the hospital on , and returned to the facility on but an 1823 form was not found in her record for the significant change.

2. Resident #2's 1823 form, dated , revealed that the type of assistance the resident required with medications was left blank.

On at approximately 1 PM, the administrator said she did not realize Resident #1's 1823 form noted the resident was a danger to herself, and the section for the type of assistance Resident #1 required with medication was left blank. She said the facility did not get an updated 1823 form after Resident #1's hospital admission.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview and record review, the facility did not provide appropriate care and services to ensure the safety through proactive measures to minimize the potential for and injuries for 1 of 5 sampled residents who was a risk (#1).

Findings:

Resident #1's record revealed a Resident Health Assessment form (1823), dated . The health

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care provider noted she had diagnosis of Parkinson's and with occasional , was a risk and a danger to herself.

Observations on at 12:30 PM during lunch time, Resident#1 sat at the dining with Resident #2 who was her spouse. Resident #2 fed her. Resident #1 had a bandage over her left eyebrow and along the left side of her face.

Review of Resident #1's record and review of the incident reports noted the following:
at 9 AM - Resident #1 found sitting on . no injury, instructed Resident #2 to call for help if he tried to put her on and off toilet by himself.
at 9 AM - Resident #1 found on no injury. Resident #2 instructed to call for help - Resident #2 said Resident #1 was on the floor, in a sitting position next to her bed; no injury - Resident #2 while helping Resident #1
at 10:20 (AM-PM not noted) - Resident #1 observed on floor in her , left side of face , sent to emergency 911 and returned at 4 AM on
Incident Report dated read, "Found on the floor in the left side of head." Steps taken to prevent recurrence was left blank
at 2 PM, license practical nurse (LPN) noted Resident #1 was resting in her recliner with hematoma to the left side of her forehead.
- continue to monitor with Resident #2 not calling for help and taking to the , himself, safety maintained
at 12:40 PM, another LPN noted Resident #1 had a on her face on the left side spreading down to her chin, remains visible
- Resident #1 found on the floor at 3:30 AM no pain. All safety measures were taken
6:30 AM - Incident report dated at 3:30 AM - Resident #1 was sitting on floor next to her wheel chair, no injury. Steps taken to prevent recurrence - Encourage to use call light
at 6 AM - Resident #1 observed on the floor in her , Resident #2 said he was taking her to the she . The Certified Nursing Assistant (CNA) told him to call for help; when she returned to the , Resident #2 again put Resident #1 on the toilet and stated "I am strong enough. I can do it." Resident #1 did not have any injury. Family member called and responded he spoke to Resident #2 numerous times about the issue; Facility will continue to follow up.
at 11:20 PM - "While making rounds writer heard resident's husband pulled the cord. Went to the resident #1 on the floor one side had big bumps noted with . Resident #2 states Resident #1 was trying to get up from the bed and . Assessment was done. Resident #1 hit head. 911 called to transfer resident to the ER for evaluation and treatment. Resident #2 left with resident #1 to the hospital
at 4 AM - Resident #1 returned to facility from ER, accompanied by Resident #2 and son-in law.

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Remind resident #2 when resident needs help or assistance, pull cord, do not help himself - close monitoring provided
incident report at 11:20 PM - noted same notes as above: Cut left side of eye
Immediate actions taken/Interventions: Assessment done - 911 Called to transfer resident to ER.
at 1:10 PM - LPN noted Resident #1 had a open area to the left side of forehead with dressing in place. remain visible.

Resident #1 was currently receiving Home Health for the injury. There were notes from the home health agency that were dated that noted moderate to the left hand with purple/blue discoloration to 3rd and 4th digits.
Provided care to left ; 2.8 centimeter (cm.) by 2.0 cm. raised hematoma with open skin throughout periphery. Scant drainage. Left /Left cheek and Red/blue.

On at 12:55 PM, staff A said Resident #2 would try to help Resident #1 and could not. The staff would tell him to call for help and not try to assist Resident #1 to the he would not. She said the night staff would now go into the to assist Resident #1 before Resident #2 could get her up as an intervention.

On at 1 PM, staff B said Resident #1 resided in the Resident #2 who would try to assist her to the calling for assistance, which resulted in Resident #1 falling. They would tell Resident #2 to always call for help but he would not because he thought he could do it himself. She said she would check on this hourly.

On at 2 PM, the LPN said Resident #2 would always try to help Resident #1. The staff would always tell him to call for help and the staff would help him with Resident #1 but he refused to do so. She said he was very protective of Resident #1.

Resident #2's record revealed an 1823, dated , noted he was independent with all activities of daily living. Facility notes, dated , revealed that Resident #2 went to a nurse to report that he while he was helping Resident #1. Observation by the nurse revealed he had a to his elbow. First aid was applied and home health was called to evaluate and treat. The nurse explained to Resident #2 the importance of getting assistance from staff when helping Resident #1 instead of him.

An interview was attempted with Resident #1 on at 2:45 PM, she said she was doing good and was sleepy. She would not say anything else. Resident #2 was guarding her and would speak for her. He would not answer questions and wanted to know the reason for the visit.

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There was no documentation found in the record to confirm there were proactive measure to minimize the that resulted in injuries other than telling Resident #2 to call for help and to use the call light. Resident #2 refused to call for help after staff instructed him to do so.

On at 3 PM, the administrator said Resident #2 refused to call for help. The facility staff had spoken with the Resident #1 and #2's family regarding the issue, and the family had also spoken with Resident #2 but he continued to try to assist Resident #1.

Class II