STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964702	R 11/28/2018
NAME OF PROVIDER OR SUPPLIER **SAVANNAH COURT OF ORANGE CITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **202 STRAWBERRY OAKS DRIVE** **ORANGE CITY, FL 32763**	

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

0000 - Initial Comments

An unannounced follow up survey to CCR# 2018010627 was conducted on at Savannah Court of Orange City (License #9243). The facility had licensure deficiencies at the time of the visit.

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

Based on observation, record review and resident and staff interview, the facility failed to have a written record for changes in condition and a hospitalization for 1 of 3 sampled residents, Resident # 1. This was previously cited on .

The findings include:

On at 9:25 AM Resident # 1 was observed lying in bed sleeping with running at 5 liters per minute. He had side rails up on both sides of bed. The Executive Director stated the resident was on hospice services and has lots of needs and were in the process of finding another location for him.

Review of Resident #1's Health Assessment (1823) revealed he had a diagnosis of , ( ), , and . It also revealed special precautions of that he self-manages and hospice was providing services. It revealed he needed assistance with ambulation and bathing. It revealed he was independent with all other activities of daily living. On page 5 of this assessment, the resident had signed it himself and dated it .

There was another Health Assessment for Resident #1 dated . It revealed diagnoses of , , , , and type 2 and . He had gait disturbances, sensory limitations, and precautions. He needed only supervision with activities of daily living except eating (which was independent).

Facility Progress notes dated revealed resident was having , distress and hospice was present. The resident wanted to go to the hospital and he was sent. He returned to the facility on . Hospice was resumed as well.
The next progress note was dated . A call was placed to hospice. The Resident had with agitation including ringing call light every 5 minutes asking for medication he doesn't have, and raising his fist and yelling verbally language. He was also removing his and bothering other residents. He was given (an medication) but it was ineffective. There was no documentation that the resident was sent to the hospital.

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There was no other progress note after the note, until an entry dated at 7:00 AM. On this date, hospice had been notified that the resident cut his tubing which deflated the balloon and the came out. Hospice nurse will be in to see the resident. At 8:00 AM, the non licensed staff member documented " a good amount of in brief". There was no documentation that the physician was notified of the coming out. Hospice records indicated the nurse did not come out to the facility until , two days after the came out and no one assessed him for 2 days.

There was another Health Assessment, which was not dated, but identified by Director of Operations as being completed after his hospitalization and the most recent assessment. It revealed additional diagnoses of , smoker, failure and , . He needed assistance to the bedside commode and was weak. He also needed person assist with ambulation, bathing, , self care, toileting and transferring. It revealed he was bedridden and posed a danger to self or others (high risk for). The two questions for requiring 24 hour nursing or , care and can this individual's needs be met in an assisted living facility was left blank. The resident needs assistance with self-administration of medications.

Review of the Mediation Records for Resident #1 showed that on /2018, the entry for had "Hospital" written in. None of his medications were documented as being given on .

On at 1:50 PM, the Executive Director confirmed the facility did not have additional documentation of the hospitalization that occurred sometime in after his behaviors were documented on . Staff began to assist with medications on 11/14/2018 so that is when they think he returned to the facility. The Executive Director stated that the facility did not want to take this resident from hospital because they were not equipped to handle his needs but the hospital discharge planner threatened to call the Agency for Healthcare Administration if they did not take him . She stated she did not have licensed staff available to monitor his administration. She confirmed the Resident was not capable of doing it himself. She also confirmed she was not providing the resident with treatments since his decline in condition. She also confirmed the hospice nurse did not come out on when the first came out as indicated in progress notes and did not come until - two days after the came out.

Review of the clinical record also did not reveal a physician order for his . The facility reached out to hospice and asked them to fax over their records for this resident. It was received on at 1:29 PM. The Hospice Registered Nurse's last visit was on . It revealed the resident was

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alert and oriented x 2, he had diminished breath sounds throughout and was [redacted] on exertion and at rest at times. It also revealed [redacted] his [redacted] order was for [redacted] liters continuously. He was [redacted] of [redacted]. He needed [redacted] with activities of daily living and was chairbound. He cut his [redacted] out on [redacted] because he was upset with staff who refused to give him a cigarette. The resident refused to have his [redacted] put [redacted] in.

Class III