STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105886	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Savannah Cove	1301 W Maitland Blvd Maitland, FL 32751

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to promote the right to self-administer medication for 1 of 4 residents reviewed for medication administration, out of a total sample of 4 residents, (#3). Findings: Review of the medical record revealed resident #3 was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD). Review of the Minimum Data Set (MDS) Admission assessment with assessment reference date of 5/29/24 revealed resident #3 had clear speech, clear comprehension, and adequate hearing and vision. The resident's Brief Interview for Mental Status score was 15 which indicated she was cognitively intact. The MDS assessment revealed she did not exhibit behavioral symptoms or reject care. Review of the medical record revealed resident #3 had a care plan for respiratory concerns related to a diagnosis of COPD and a history of pulmonary embolism, initiated on 5/23/24. The goal was the resident would maintain adequate oxygenation. The interventions included offer and administer medications as ordered. On 6/12/24 at 3:29 PM, resident #3 had a hand-held puffer-type inhaler on the tray table beside her bed. The Albuterol 90 microgram inhaler was openly displayed, and the resident confirmed it was her medication. She explained she sometimes had severe attacks due to her COPD, so she always kept the rescue inhaler nearby in case she experienced difficulty breathing. Resident #3 stated her doctor felt it was important she kept the inhaler with her. She said, I've had it with me since I've been here. Right here on the table. I need to be able to reach it. Albuterol is a drug that relaxes muscles in the airways and increases air flow to the lungs. It is used treat people with asthma or certain types of COPD (retrieved on 6/14/24 from www.drugs.com/albuterol.html). Review of the medical record revealed resident #3 had a physician order dated 5/22/24 for Albuterol 15 milligrams per 3 milliliters solution via nebulizer, every four hours as needed. There were no physician orders for an Albuterol inhaler or to authorize the resident to self-administer medications. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 3:53 PM, resident #3 was no longer in her room, but the Director of Nursing (DON) validated there was an inhaler on the tray table. She confirmed residents should not have any medications, neither over-the-counter nor prescription, at the bedside, unless they were assessed and determined to be capable of self-administration. The DON retrieved the inhaler from the table and gave it to resident #3's assigned nurse. On 6/12/24 at 4:28 PM, resident #3 returned to her room and discovered her inhaler was not on the tray table. She informed the DON, I want it back. My doctor wants me to have it. The DON told the resident it was her right to keep the inhaler, and if a nursing assessment showed she was able to self-administer the medication, the nurse would obtain the appropriate physician order for her to do so. Review of the facility's policy and procedure for Resident Rights - Self Administration of Medication Program (undated) revealed the facility would allow residents to self-administer medication if the interdisciplinary team (IDT) deemed it clinically appropriate. The document indicated once the resident was deemed safe to self-administer medication, the facility would obtain a physician order for the specific medication. The facility would determine where the medication would be stored and who would be responsible for documentation of administration. The policy revealed the resident's care plan would be updated to reflect the her ability and authorization to self-administer medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to honor the right to choose the type and frequency of baths for 1 of 4 residents reviewed for activities of daily living (ADLs), out of a total sample of 4 residents, (#3). Findings: Review of the medical record revealed resident #3 was admitted to the facility on [DATE] with diagnoses including bilateral hip fractures, arthritis of the hips and right knee, generalized muscle weakness, unsteadiness on her feet, repeated falls, syncope and collapse, and chronic obstructive pulmonary disease. The Minimum Data Set (MDS) Admission assessment with assessment reference date of 5/29/24 revealed resident #3 had adequate vision and hearing, clear speech, clear comprehension, and no issues making herself understood. She had a Brief Interview for Mental Status score of 15 which indicated she was cognitively intact. The MDS assessment showed resident #3 exhibited no behavioral symptoms and did not reject evaluation or care that was necessary to achieve her goals for health and well-being. The document revealed it was very important for the resident to choose the type of bath she received, whether a tub bath, shower, or sponge bath. The document indicated the resident required supervision or touching assistance for showering or bathing. Review of the medical record revealed resident #3 had a care plan for self-care deficit related to decreased mobility and weakness requiring assistance with ADLs, initiated on 5/23/24. The goal was the resident would have her ADL care needs met daily. The interventions revealed nursing staff would assist the resident with bathing and personal hygiene, and assist to shower 2 x week per schedule. Review of the Resident Preference form completed on admission, dated 5/22/24, revealed resident #3 expressed a preference for morning showers. The Shower Schedule indicated resident #3's room/bed number was scheduled for showers on Sundays and Wednesdays on the 7:00 AM to 3:00 PM shift. The document included instructions for staff to do nail care and wash residents' hair with all showers, and report and document refusal. On 6/12/24 at 3:29 PM, when asked if she received her showers or baths according to her preferences, resident #3 said, I haven't had a shower in over a week. I've been here three weeks and I've had a total of two showers. I feel like a sweat hog. I feel like I stink. She pointed to her hair which appeared stringy and greasy. The resident explained the facility did not even leave disposable wipes in the bathroom so she could do her own personal hygiene care. On 6/12/24 at 4:28 PM, resident #3 informed the Director of Nursing (DON) she received only two showers since she was admitted to the facility three weeks ago. The DON stated the resident could get as many showers as she wanted, as often as daily if she chose. Resident #3 explained she was only offered showers on two occasions and she accepted both as staff told her those were her shower days. The resident stated she was not aware which days were assigned for her showers. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 4:35 PM, the DON verified Certified Nursing Assistants (CNAs) were to offer residents a minimum of two showers weekly according to the schedule. She explained her expectation was staff would meet residents' needs while honoring their preferences. She validated resident #3's experience was unacceptable. On 6/12/24 at 5:04 PM, the DON provided Shower Review forms that showed resident #3 had showers on Sunday 5/26/24 and Wednesday 5/29/24. She was unable to find any documentation of a shower over the last fourteen days. She explained she found a Shower Review form for today that indicated CNA B gave resident #3 a bed bath during the 7:00 AM to 3:00 PM shift. On 6/12/24 at 5:12 PM, resident #3 was informed there was documentation she received a bed bath today. She said, I know what a bed bath is. It's when they take off all your clothes and they bathe you in bed. The resident appeared surprised and stated she never had a bed bath for the entire time she was in the facility. She reiterated she was accustomed to taking regular showers when at home. On 6/13/24 at 1:18 PM, the DON validated honoring residents' choices and preferences was a priority. She explained showers and baths were important aspects of care that facilitated both physical and mental healing processes. Review of the facility's policy and procedure for Activities of Daily Living (ADLs)/Maintain Abilities (undated) revealed the facility would honor and support the principles of quality of life by providing person-centered care that honored each resident's preferences.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to implement interventions to ensure the optimal nutritional status for 1 of 1 resident reviewed for assisted nutrition and hydration via tube feeding, out of a total sample of 4 residents, (#1). Findings: Review of resident #1's hospital record revealed he had a past medical history of stomach cancer. The record showed the resident received and tolerated tube feedings through a jejunostomy tube (J-tube) that was placed during his hospitalization . A jejunostomy tube or J-tube is a soft, plastic tube placed through a surgical opening in the skin of the abdomen into the midsection of the small intestine. The tube is used to deliver food and medicine for patients who cannot process food in the stomach (retrieved on 6/24/24 from www.medlineplus.gov). A Communication Form with the date of action 5/22/24 at 5:00 PM, provided facility staff with pre-admission information for resident #1. The document indicated he required equipment for tube feeding. A Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form dated 5/22/24 revealed resident #1's primary diagnosis in the hospital was syncope, and other diagnoses included stomach cancer and iron deficiency anemia. The document indicated he was alert, oriented, and followed instructions. The section of the form designated for Nutrition/Hydration showed the resident received tube feeding via J-tube and other supplements, but the document did not include instructions for a specific type or rate of tube feeding formula. Review of the medical record revealed resident #1 was admitted to the facility on [DATE] with diagnoses including dysphagia or difficulty swallowing, stomach cancer, malabsorption due to intolerance, and iron deficiency anemia. Review of the Admission Nursing Evaluation, dated 5/22/24 at 6:30 PM, revealed resident #1's nutritional needs were met by a feeding tube, pureed diet, and nectar liquids. Review of an Initial Baseline Care Plan Meeting form, dated 5/23/24, revealed resident #1's nursing needs included J-tube site care with tube feeding as ordered. The document indicated he had a diet order for pureed texture foods, nectar-thick consistency for fluids, and J-tube feedings. Resident #1 had a care plan for the potential for complications related to J-tube feedings, initiated on 5/23/24. The care plan revealed the resident had stage 4 stomach cancer and the goal was he would tolerate tube feedings without complications. The interventions included administer tube feedings as ordered by the physician and monitor tolerance of J-tube feedings. A care plan for cancer, initiated on 5/23/24, revealed resident #1 had the potential for complications due to stage 4 stomach cancer. The document indicated his J-tube was placed for alternate nutrition. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Physician Orders for resident #1 revealed orders dated 5/22/24 for J-tube flush and check residual every shift, and a puree/nectar diet type. Review of Departmental Notes revealed a nursing progress note written by the Director of Nursing (DON) dated 5/22/24 at 10:27 PM. The note indicated the DON called the hospital to verify resident #1's diet and tube feeding orders but was unable to obtain the information. The DON contacted the Physician Assistant and noted she received an order to hold tube feed for now until evaluation from speech [therapist]. Review of resident #1's medical record revealed a handwritten order by the Speech Therapist dated 5/23/24 for pureed solids and nectar consistency liquids. A Dietary progress note dated 5/24/24 at 10:09 AM, revealed the Registered Dietitian (RD) interviewed and assessed resident #1 and noted he required tube feeding via his J-tube to meet his nutritional needs due to a diagnosis of stomach cancer. The note read, He is able to consume [oral] diet of puree, nectar hick liquids. Intake of food minimal. The RD calculated resident #1's daily estimated nutrient needs as 2200 to 2672 calories and 2600 milliliters (ml) of fluids. Her recommendation was for administration of TwoCal HN tube feeding formula at 85 ml/hour for a total volume of 1000 ml daily, 60 ml of water before and after the tube feeding, and Ensure nutritional supplement, one can twice daily, to provide an additional 500 calories and 20 grams of protein per day. Review of the resident's medical record revealed a nursing progress note dated 5/26/24 at 4:55 AM that indicated his tube feeding was infusing at 85 ml/hour. However, review of the medical record revealed the order for the tube feeding was not added to the electronic medical record (EMR) until 5/27/24, three days after it was written. On 6/12/24 at 8:45 AM, in a telephone interview, resident #1 recalled before he was discharged from the hospital, he was assured the facility would have his tube feeding formula and equipment ready for his arrival. However, the resident explained he did not receive tube feedings for three to four days after admission to the facility. He stated he was offered thickened liquids and pureed food during that period, but he was not able to consume much of the items provided. Resident #1 verbalized thorough knowledge of his daily caloric needs and stated he required 1000 ml daily of a high-calorie tube feeding formula and an additional 500 calories daily from oral nutritional supplement drinks. On 6/12/24 at 11:27 AM, the Speech Therapist stated she evaluated and treated resident #1 during his stay in the facility. She recalled she trialed different foods with the resident. She stated she assessed his ability to chew and swallow scrambled eggs and noted he still had residue left in his mouth after he swallowed. The Speech Therapist stated resident #1 also failed the test for his ability to swallow thin liquids. She explained she assessed his swallowing only, not his dietary needs. On 6/12/24 at 2:17 PM and 2:59 PM, the DON stated she contacted the RD on 5/23/24, the day after resident #1 was admitted . She verified the RD wrote recommendations on 5/24/24, and a nurse wrote the order on 5/25/24. The DON recalled she contacted the facility on 5/25/24 to instruct the nurse to obtain a tube feeding pump from the supplier. The DON validated the medical record indicated the resident's food intake was on the lower end during the days prior to obtaining the order for tube feeding. She acknowledged there was a delay in initiating resident #1's tube feeding. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 4:00 PM, the RD stated she received a voicemail from the DON late in the day on 5/23/24, possibly after working hours, regarding resident #1's tube feeding. She stated she assessed the resident the following morning, on 5/24/24, and calculated his nutritional needs based on his height, weight, and need for additional nutrients due to his cancer diagnosis. The RD confirmed resident #1 was very aware of his nutritional needs. She said, His needs were not being met in the days prior to my order as he could not consume the required calories orally. My expectation was that they would start it as soon as possible. The RD stated she visited the facility on the evening of 5/27/24, and noted no evidence of a tube feeding hanging on pole. She stated she spoke with his assigned nurse, Licensed Practical Nurse (LPN) A, who checked the electronic medical record and informed her there was no order for tube feeding. On 6/12/24 at 4:45 PM, LPN A recalled she was assigned to resident #1 on 5/27/24 during the 3:00 PM to 11:00 PM shift when the RD approached her about the resident's tube feeding. LPN A confirmed there was no order for a tube feeding in the medical record at that time, and the RD asked her to transcribe an order from her written recommendation. LPN A stated a tube feeding pump was in the resident's room and she programmed it to reflect the ordered flow rate. She stated there were two bottles of TwoCal HN formula on the resident's dresser and she recalled she saw him arrive with two containers on the day he was admitted . On 6/13/24 at 12:41 PM, in a telephone interview, a Sales Representative for the facility's medical equipment supply company stated a facility nurse called to order a tube feeding pump on 5/25/24 at 3:10 PM and the device was delivered less than two hours later, at 5:00 PM. On 6/13/24 at 1:08 PM and 1:48 PM, the DON stated her expectation was nurses would transcribe physician orders to the electronic medical record to ensure all nurses were aware of the care and services to be provided for residents. The DON did not respond when asked why the device was not ordered for three days, and she could not explain why the dietitian was not contacted prior to admission or during the work day on 5/23/24. The Administrator confirmed tube feeding pumps did not have to be ordered by a nurse. She explained Admissions staff could also order necessary medical equipment. Review of the facility's policy and procedure for Enteral Feeding (undated) read, It is the policy of the facility to provide adequate nutrition and hydration to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. The policy indicated the admitting nurse would obtain physician orders for tube feeding, and the dietitian would be notified of the orders and assess the resident's nutrition and hydration needs. The document revealed the nurse would review the dietitian's recommendations with the physician and obtain an order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview and record review, the facility failed to provide pharmaceutical services to ensure the accuracy of acquisition and administration of anti-seizure medication for 1 of 4 residents reviewed for medication administration, out of a total sample of 4 resident, (#1). Findings: Review of resident #1's hospital record revealed a History and Physical note, dated 5/14/24, that showed he presented to the Emergency Department with a chief complaint of a fall. The document read, Patient stated he fell 2 days ago. Patient stated he fell forward in his home after failing to take his seizure medication on time. Resident #1 was discharged from the hospital to the facility on [DATE] with medication orders that included Carbamazepine 200 milligrams (mg), take two tablets in the morning and two tablets at bedtime, a total of 800 mg daily. Carbamazepine is an anticonvulsant drug which works by decreasing nerve impulses that cause seizures. Patients should take Carbamazepine exactly as prescribed by your doctor (Retrieved on 6/14/24 from www.drugs.com/carbamazepine.html). Review of the facility's medical record revealed resident #1 was admitted on [DATE] with diagnoses including epilepsy, syncope and collapse, and a history of falling. Resident #1 had a care plan for the potential for injury and complications related to his seizure disorder, initiated on 5/23/24. The goal was the resident would not show signs or symptoms of seizure activity. The document included the intervention for nurses to administer medication as per orders. Review of Physician Orders for May 2024 revealed an order dated 5/22/24 for Carbamazepine 200 mg, give one tablet twice daily for epilepsy. The physician order was transcribed to the Medication Administration Record (MAR), and nurses administered one tablet twice daily during resident #1's 6-day stay in the facility. The resident received one tablet twice daily, a total of 400 mg daily, rather than the intended dose of 800 mg daily. On 6/12/24 at 8:45 AM, in a telephone interview, resident #1 stated he chose to discharge himself from the facility on 5/28/24 as he was not satisfied with the care and services. The resident stated he asked nurses about the dosage of his Carbamazepine because he started to feel bad after taking it, but they never provided him with the requested information. He said, I know something was off with my Carbamazepine dose. On 6/12/24 at 2:17 PM, the Director of Nursing (DON) confirmed there was a discrepancy between the hospital's discharge medication order for resident #1's Carbamazepine and the facility's medical record. She validated the transcription was inaccurate and the resident received the wrong dose of medication during his stay. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 1:08 PM, the DON stated the Interdisciplinary team reviewed the charts of newly admitted residents in the daily clinical meeting. She explained during the process, they compared the hospital discharge orders to the orders entered into the facility's medical record. The DON acknowledged the team missed the incorrect dosage of resident #1's Carbamazepine on the facility's MAR. Review of the facility's policy and procedure for Pharmacy Services (undated) revealed the facility would provide pharmaceutical services that included procedures to ensure the accurate acquiring, dispensing, and administration of all drugs to meet the needs of each resident.