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	02/15/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to promptly notify the physician of an unwitnessed fall for a resident at high risk for bleeding, for 1 of 4 residents reviewed for fall risk, of a total sample of 8 residents, (#4). Findings: Review of the medical record revealed resident #4, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included atrial fibrillation, stroke, lack of coordination, repeated falls, generalized muscle weakness, unsteadiness on her feet, and Alzheimer's disease. Review of the Minimum Data Set (MDS) Quarterly assessment with assessment reference date of 10/16/24 revealed resident #4 had a Brief Interview for Mental Status score of 6/15 which indicated she had severe cognitive impairment. The resident had functional limitation in range of motion with impairment of one leg and used a wheelchair for mobility. The MDS assessment showed resident #4 received a high-risk drug, an anticoagulant or blood thinner, in the look back period. Review of a Post Fall Evaluation dated 1/01/25 at 11:30 PM, revealed resident #4 fell in the facility's activity room. The document indicated the attending physician was notified of the unwitnessed fall on 1/01/25, but it did not include the time the notification was made. A Physician Progress Note dated 1/02/25 at 9:45 AM, revealed resident #4's attending physician assessed her almost 12 hours after she fell . The document indicated the reasons for the visit were management of anticoagulant medication and geriatric falls. The progress note read, The most recent fall occurred hours(s) ago indoors and at the nursing home. The physician noted resident #4 had a contusion or bruise, and a hematoma to the left side of her forehead. A hematoma is a raised, bruised area resulting from a collection of clotted blood due to an injury or trauma (retrieved on 2/19/25 from www.my.clevelandclinic.org/health/diseases/15235-bruises). The physician indicated the resident would be sent to the hospital for evaluation of her head injury, secondary to a fall. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2025
NAME OF PROVIDER OR SUPPLIER Savannah Cove		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Interdisciplinary Team (IDT) progress note dated 1/02/25 revealed on 1/01/25, resident #4's assigned nurse heard moans and discovered her on the floor. The IDT note indicated the assigned nurse assessed the resident, noted no injuries, and placed a call to the Advanced Practice Registered Nurse (APRN) to inform her of the accident. The document revealed the assigned nurse gave change of shift report to the oncoming nurse regarding monitoring the resident. The IDT note did not indicate the APRN responded to the call or message from the facility, nor that the assigned nurse made additional attempts to follow up and notify a provider throughout the following 8-hour shift. The document revealed the provider made routine rounds the following morning and was made aware of resident #4's injury at that time. On 2/14/25 at 3:52 PM, Registered Nurse (RN) M recalled resident #4 was agitated on the night of 1/01/25 so she asked Certified Nursing Assistants (CNAs) to keep her in a common area and monitor her closely. RN M stated a while later she was in the hallway and heard a moan from the activity room. She explained a CNA left resident #4 unattended, and she fell from the wheelchair to the floor. RN M stated the incident occurred just before the change of shift and she informed the oncoming night shift nurse the resident had fallen and had no injuries. RN M explained she placed a call to the APRN but did not receive a call back. She stated she left the facility at about 1:00 AM and as of that time, the APRN had not called back. RN M confirmed she did not make another attempt to notify the physician or APRN of the unwitnessed fall. On 2/14/25 at 1:36 PM, in a telephone interview, Licensed Practical Nurse (LPN) K confirmed RN M told her resident #4 fell during the evening shift and did not appear to have hit her head. She recalled RN M informed her the family and Director of Nursing (DON) had already been notified and she was awaiting a call back from the on-call provider. LPN K confirmed there was no call back from the physician or APRN, and she did not pursue any follow up to ensure provider notification was made. LPN K recalled the attending physician walked into the facility at about 9:15 AM the next morning to do her regular rounds at about the same time day shift staff discovered the resident's hematoma. She stated the physician immediately gave an order to send the resident to the hospital. On 2/14/25 at 12:59 PM, the DON stated her expectation was nurses would perform an assessment after a resident fell and notify the physician immediately. She explained resident #4 received a blood thinner and was therefore at high risk for bleeding in the brain if she hit her head. The DON explained the nurse stated she called the provider but never spoke to anyone and she never received a call back. The DON stated it was essential to notify the physician of a possible head injury and if after two attempts nurses were unable to contact a provider, they should contact her. The DON stated she would have contacted the provider herself or reached out to the facility's Medical Director for orders. Review of the job description for Registered Nurse, dated 10/18/11, revealed duties and responsibilities included documenting and reporting incidents and changes in health to the physician in a timely and accurate manner. Review of the job description for Licensed Practical Nurse, dated 2020, revealed major duties and responsibilities included documenting and reporting resident care problems and changes in residents' conditions to the physician and supervisor. (continued on next page)

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	105886	A. Building B. Wing	02/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy and guidelines for Assessing Falls and Their Causes, dated March 2018, revealed instructions to nurses to consult with the physician in providing care and diagnostic services, and notify the physician of any resident accidents or incidents and changes in condition.

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility neglected to provide necessary care and services to prevent falls and a fall-related injury and ensure appropriate post-fall monitoring and evaluation, for 1 of 4 residents reviewed for fall risk, of a total sample of 8 residents, (#4); and failed to maintain effective processes to educate staff and offer adequate supervision to meet the needs of all residents at risk for falls. The facility's failure to appropriately monitor residents with cognitive and/or physical impairments resulted in actual harm for resident #4, and placed all residents who required increased supervision at risk for injury. Resident #4, a physically and cognitively impaired resident, received blood thinner medication and had a history of repeated falls. On 12/22/24, the Certified Nursing Assistant (CNA) assigned to supervise residents in the fall prevention program in the activity room left the residents unattended, and resident #4 fell from her wheelchair to the floor. Ten days later, another CNA left the resident alone in the activity room and she had another unwitnessed fall from the wheelchair. Assigned nurses neither initiated neurological checks nor notified with the physician until almost 12 hours after the fall when staff discovered the resident had a bruise and a golf ball sized hematoma on her forehead. The resident suffered pain and anxiety, and required transfer to the hospital for diagnostic testing to rule out a brain bleed. Findings: Cross reference F689. Review of the medical record revealed resident #4, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included atrial fibrillation, stroke, lack of coordination, repeated falls, generalized muscle weakness, unsteadiness on her feet, right knee contracture, anxiety disorder, paranoid schizophrenia, and Alzheimer's disease. Review of the Minimum Data Set (MDS) Quarterly assessment with assessment reference date of 10/16/24 revealed resident #4 had a Brief Interview for Mental Status score of 6/15 which indicated she had severe cognitive impairment. She had fluctuating inattention which changed in severity and continuous disorganized thinking. Resident #4 had functional limitation in range of motion with impairment of one leg and used a wheelchair for mobility. She required substantial or maximal assistance for mobility and transfers and did not walk. The MDS assessment showed resident #4 received a high-risk drug, an anticoagulant or blood thinner, in the look back period. Resident #4's medical record revealed a care plan for fall risk, initiated on 2/07/23, which indicated she was unable to ambulate or transfer independently and had fall risk factors including decreased mobility, weakness, psychiatric medications, and cognitive deficits. The goal was resident #4 would not sustain a major fall-related injury by utilizing fall precautions as evidenced by observation and documentation. Interventions included participation in the fall risk program, remind to ask for help but recognize that the resident might not remember to ask, and escort to activity programs. (continued on next page)

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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 0600

Level of Harm - Actual harm

Residents Affected - Few

A care plan for impaired mobility, initiated on 2/22/24, revealed resident #4 required ongoing assistance with mobility. The goal was she she would be out of bed daily in her wheelchair and transfer with assistance from one staff member. Review of a care plan for cognition, initiated on 2/22/24, revealed the resident's confusion and a language barrier affected her comprehension. Interventions included provide a safe and structured environment.

On 2/14/25 at 12:24 PM, and 2:10 PM, the Director of Nursing (DON) explained the facility initiated a fall prevention program to provide enhanced or increased monitoring for residents at risk for falls. The DON stated either activities assistants or CNAs who were assigned to the floor monitored these residents in the activity room. She verified resident #4 was at high risk for falls and needed to participate in the fall prevention program. The DON reviewed resident #4's fall on 12/22/24 at 1:45 PM. She stated resident #4 was one of the residents in the fall prevention program. She explained the resident was found on the floor and the assigned CNA verified she was not in the activity room at the time. The DON said, We were doing 1-hour rotations for fall prevention and all CNAs shared the responsibility. She stepped out to give a resident a shower on instruction of a nurse. She stated the facility educated CNAs and nurses regarding endorsing the supervision task to another staff member before leaving the room.

Review of an Education/In-Service Attendance Record dated 12/22/25 and titled 1 to 1 Supervision revealed the Administrator educated staff on the expectations for one-to-one supervision of residents. The program description read, When on 1:1 supervision as assigned, you cannot leave the resident(s) you are supervising unless coverage is there to relieve you. If you need to leave and no coverage, notify nurse. When on 1:1 you are responsible for that resident. Reconciliation of the attendance sheet with the facility's employee list revealed signatures for a total of 13 staff members including 4 of 11 Registered Nurses (RNs), 2 of 7 Licensed Practical Nurses (LPN) and 7 of 27 CNAs.

On 2/14/25 at 10:25 AM, Activities Assistant P was seated in the activity room with four residents. She explained none of the residents required one-to-one supervision, but she watched over them while they were in the room.

On 2/15/25 at 9:34 AM, Activities Assistant Q stated she was assigned to the activity room every Saturday from about 9:30 AM until lunchtime. She explained not all residents in the room were at risk for falls, and indicated only one of the six residents present was a fall risk. Although resident #4 was in the room, Activities Assistant Q pointed to another resident and when asked, denied resident #4 was the person at risk for falls.

On 2/15/25 at 2:07 PM, the Administrator verified as the facility's Risk Manager, his duties included implementing interventions and processes to prevent recurrence of incidents and ensure the safety of residents. He confirmed resident #4 fell in the activity room on 12/22/24 when the assigned CNA left the residents unattended, and as a result, he initiated education on expectations for the fall prevention program to ensure the residents received the required level of supervision. The Administrator was informed only 13 of 45 nursing staff received the in-service, and no activities staff were included even though they were assigned to monitor residents in the activity room. He acknowledged the in-service did not reach an adequate number of staff and it was apparent that education did not continue after the day he initiated it.

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NAME OF PROVIDER OR SUPPLIER Savannah Cove		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few	On 2/14/25 at 12:24 PM, the DON verified resident #4 had another unwitnessed fall in the activity room on 1/01/25 at 10:30 PM. She explained the resident was with a CNA who was charting in the activity room, and the CNA left her unattended to respond to a call light. The DON stated at the time the assigned nurse assessed her, the resident had no injuries, but the following day staff discovered a hematoma on her forehead. She confirmed the assigned night shift nurse did not perform neurological checks and the developing hematoma went unnoticed. According to the Agency for Healthcare Research and Quality (AHRQ), there is an increased risk of intracranial hemorrhage (bleeding in the brain) in elderly patients on anticoagulant therapy. The AHRQ indicates important clinical communications include documentation of the incident, outcome, and initial and ongoing observations, and an updated care plan in the medical record; and the medical provider should be notified at the time of the incident. Since there may be late manifestations of head injury even after 24 hours, it is necessary to perform neurological checks or neurochecks for 72 hours to evaluate and monitor residents after falls. Neurochecks include monitoring of vital signs, pupil size and reaction to light, reflexes, movement, and level of consciousness (retrieved on 2/24/25 from www.ahrq. gov/patient-safety/settings/long-term-care/resource/injuries/fallspx/man2.html). On 2/15/25 at 10:03 AM, the DON stated her expectation was nurses would adhere to accepted standards of practice and conduct post-fall neurochecks immediately after the incident, every 15 minutes for one hour, then every 30 minutes, with increasing intervals up to 72 hours, or until discontinued by the physician. Review of an Interdisciplinary Team (IDT) progress note dated 1/02/25 revealed on 1/01/25, resident #4 was agitated and attempted to get out of bed. The note indicated staff intervened for safety reasons, assisted her to her wheelchair, and brought her to the unit's common are for observation. The document revealed a while later, resident #4 was found on the floor. The assigned nurse called the Advance Practice Registered Nurse (APRN) to report the fall and then gave shift change report regarding the incident to the oncoming night shift nurse. The IDT note showed no actions taken related to closely monitoring the resident's status during the night shift, additional attempts to notify the provider, and obtaining appropriate orders. The document revealed the provider arrived at the facility the following morning to round and assessed resident #4 at that time. The physician instructed staff to send the resident to the hospital for evaluation due to her fall and head injury with the risk factor of receiving blood thinner medication. On 2/14/24 at 10:42 AM, resident #4's daughter stated her mother fell in the activity room a little over a month ago. She explained it was a scary incident as her mother was on blood thinners and hit her head when she fell . She recalled her mother's face was badly bruised for a while, but fortunately she did not suffer a brain bleed. The resident's daughter stated hospital staff emphasized that her mother needed to got to the hospital for evaluation after any falls with possible head injuries. She stated the facility informed her the CNA who was with her mother got up and left her alone in the activity room. (continued on next page)

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	105886	A. Building B. Wing	02/15/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	On 2/14/25 at 3:52 PM, RN M stated resident #4 was at high risk for falls and often required increased supervision from staff to ensure her safety. She explained there were several other residents who were at high risk for falls and providing adequate supervision for them all was challenging. RN M recalled on 1/01/25, resident #4 was agitated and staff brought her to the nurses' station to monitor her. RN M stated she was occupied with another resident who needed to be transferred to the hospital and she told the three CNAs on the unit that someone needed to watch resident #4. She recalled when she finished with the other resident, she heard a moan from the activity room, and discovered resident #4 on the floor. RN M said, They weren't paying attention to me. I don't know why she was abandoned in the activity room. I felt like it was insubordination by the CNAs as several times I told them to sit with her. She explained the resident did not appear to have any injuries and she handed over her care to the oncoming night shift nurse. RN M confirmed she did not initiate neurochecks even though the fall was unwitnessed and it was unknown if the resident hit her head. She explained the resident was on her back and appeared to have slid to the floor. RN M acknowledged the resident's use of a blood thinner increased her risk for a serious brain bleed related to a head injury. She stated she called the APRN and left a message but never received a call back, and she did not attempt to notify or obtain orders from another provider. On 2/14/25 at 1:36 PM, in a telephone interview, LPN K recalled she received shift change report from RN M on 1/01/25 regarding resident #4's fall, and was told the post-fall assessment was negative and she did not seem to have hit her head. LPN K stated RN M informed her the APRN had not yet returned her call. She remembered when she arrived for her shift, all staff were arguing about who was supposed to have been supervising the resident. She stated a CNA sat with resident #4 until she started falling asleep in the wheelchair and staff then put her to bed. LPN K stated the resident slept throughout the night and she did not see her until the next morning when the day shift CNA got her out of bed and brought her out of her room. LPN K said, I looked at her and noticed discoloration to the side of her head. I said she doesn't look right. She confirmed she had not followed up with the APRN during her shift nor perform neurochecks since RN M had not initiated them. LPN K acknowledged if a resident had an unwitnessed fall, neurochecks should be done because there might be a head injury. She explained residents on blood thinners who had an unwitnessed fall should be sent to the hospital for testing. On 2/15/25 at 11:43 AM, the DON verified although resident #4 was a known fall risk, she had two unwitnessed falls over a 10-day period when CNAs left her unattended in the activity room. However, she stated she felt the resident was adequately supervised on both occasions as she did not have a care plan for one-to-one supervision. She acknowledged the first fall occurred when the assigned CNA left the group of residents in the fall prevention program and the second fall occurred after a CNA ignored a nurse's explicit instruction to remain with resident #4. The DON confirmed resident #4's physician was not informed of the second fall for almost 12 hours, and the resident remained in the facility without being appropriately monitored by nurses, but she reiterated, I would not say it was neglect. Review of the facility's policy and procedures for the Abuse Prevention Program, revised in August 2006, revealed residents had the right to be free from abuse and neglect. The policy listed components for the prevention of neglect that included staff training, identification of occurrences and patterns of potential abuse or neglect, conducting ongoing review and analyses of incidents, and implementing changes to prevent future occurrences. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2025
NAME OF PROVIDER OR SUPPLIER: Savannah Cove		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Facility assessment dated [DATE] revealed the facility was able to meet the needs of residents with common diseases, conditions, and physical and cognitive disabilities such as impaired cognition, anxiety disorder, behavior that required intervention, Alzheimer's disease, muscle weakness, and a history of falling. The Facility Assessment revealed staff would provide person-centered care by identifying hazards and risks and preventing abuse and neglect.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to implement its abuse and neglect prohibition policy and procedures related to conducting a thorough investigation of a fall with injury to rule out neglect, determine if reporting was necessary, and ensure the safety of 1 of 4 residents reviewed for fall risk, of a total sample of 8 residents, (#4). Findings: Review of the facility's policy and procedures for the Abuse Prevention Program, revised in August 2006, revealed residents had the right to be free from abuse and neglect. The policy listed components for the prevention of neglect that included staff training, identification of occurrences and patterns of potential abuse or neglect, protection of residents during investigations, timely and thorough investigations of all reports and allegations, reporting and filing accurate documents related to incidents, conducting ongoing review and analyses of incidents, and implementing changes to prevent future occurrences. The facility's policy and procedures for Accidents and Incidents - Investigating and Reporting, revised in July 2017, revealed the nursing supervisor would complete and submit a Report of Incident/Accident form to the Director of Nursing (DON) within 24 hours of the incident. The DON was responsible for ensuring the facility's Administrator received a copy of each incident report. The policy indicated the facility would review incident/accident reports to identify trends and analyze individual resident's vulnerabilities. Review of the medical record revealed resident #4, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included atrial fibrillation, stroke, lack of coordination, repeated falls, generalized muscle weakness, unsteadiness on her feet, and Alzheimer's disease. Review of an incident report dated 12/22/24 at 1:45 PM revealed resident #4 fell from her wheelchair in the activity room. The document indicated a Physical Therapist, a Certified Nursing Assistant (CNA), and a nurse assisted the resident from the floor and returned her to her wheelchair. The report revealed the Advanced Practice Registered Nurse (APRN) was notified of the fall, and she instructed the nurse to monitor resident #4 for changes. Review of staff statements obtained during the incident investigation revealed resident #4 was one of a group of residents in the facility's activity room. The residents were supposed to be under direct supervision of an assigned CNA, who explained she left the residents in the room to attend to another resident who needed a shower. Her statement indicated the housekeeper was in the room when she left her assigned location. The housekeeper's statement revealed she was in the activity room to clean up a mess, and did not witness resident #4's fall. Statements from both Registered Nurses (RNs) on schedule revealed resident #4 yelled and was found on the floor with her coloring book nearby. (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of an incident report dated 1/01/25 at 10:30 PM revealed resident #4 was again found on the floor next to her wheelchair, in the activity room. The document indicated she had once more been left unattended in the room, The report listed her predisposing fall risk factors including confusion, drowsiness, and impaired memory. Review of staff statements revealed resident #4's assigned CNA left her in the activity room to be monitored by another CNA who was in the room charting. As with the resident's previous fall, the CNA who was charting left her unattended in the activity room and nurses discovered the resident on the floor. The assigned CNA's statement revealed after she assisted staff to pick resident #4 up off the floor, the CNA who left the resident unattended told her she did not stay because the assigned CNA was gone for a long time.

Review of a Post Fall Evaluation note, dated 1/01/25 at 11:30 PM, revealed resident #4 fell in the facility's activity room on 1/01/25 at 10:30 PM. The document indicated the fall was unwitnessed. The document read, Reason for fall: Resident unattended in activity room. CNA's at nurse's station told 3 times to not leave resident unattended.Resident left unattended in activity room, while I was giving report to [Emergency Medical Services] to send another resident to the hospital.

Review of an Interdisciplinary Team (IDT) progress note dated 1/02/25 revealed on 1/01/25, resident #4 was agitated and attempted to get out of bed. The note indicated staff intervened for safety reasons, assisted her to her wheelchair, and brought her to the unit's common are for observation. The document revealed resident #4 was coloring in the activity room when she reached down to pick up a coloring pencil and fell out of her wheelchair. The assigned nurse called the APRN to report the fall and gave shift change report regarding the incident to the oncoming night shift nurse. The IDT note showed no actions taken related to closely monitoring the resident's status during the night shift, additional attempts to notify the provider, and obtaining appropriate orders. The document revealed the provider arrived at the facility the following morning to round and assessed resident #4 at that time. The physician instructed staff to send the resident to the hospital for evaluation due to her fall and head injury with the risk factor of receiving blood thinner medication.

On 2/14/25 at 2:10 PM, the DON stated the facility had a fall prevention program which provided increased supervision and enhanced monitoring for residents who were at risk for falls. She explained these residents were to remain in the activity room under close supervision of either an activities assistant or CNAs assigned to the floor who took turns for rotating 1-hour shifts. The DON verified resident #4 was a high risk for falls and needed to be supervised in that program.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/15/25 at 11:43 AM, the DON confirmed resident #4 fell on [DATE] when she was left unattended in the activity room. She stated the root cause analysis was the resident fell when she reached for her coloring book as that is what she was told by staff. She was unable to clarify how staff could be certain the fall occurred in that way if it was unwitnessed. The DON explained she did not believe there was an element of neglect related to the fall, even though the CNA assigned to monitor all the residents in the activity room left her post. Review of the facility's investigation of resident #4's fall on 1/01/25 revealed she had another unwitnessed fall from the wheelchair in the activity room. The DON said, The root cause was she fell unassisted. She was informed that was a description of the circumstances of the fall, but did not indicate the root cause. She stated the staff 's description of the environment indicated the resident probably tried to pick up her coloring supplies from the floor. When asked if the root cause should have been that the resident was left unattended, and therefore possibly neglected due to lack of adequate supervision, the DON stated she considered that option but determined the resident did not have an active intervention for one-to-one supervision. The DON acknowledged the Post Fall Evaluation dated 1/01/25 indicated the assigned nurse determined resident #4 required close supervision and she instructed CNAs multiple times not to leave the resident unattended. The DON confirmed her investigation showed the CNAs did not follow the nurses instructions to ensure the resident's safety, the resident fell when left by unattended, the provider was not notified, and the resident was not monitored closely for bleeding, but her investigative findings did not indicate neglect. On 2/15/25 at approximately 11:50 AM, the Administrator stated as the facility's Risk Manager, he was ultimately responsible for implementing the abuse and neglect policy and procedures to determine if an incident could have involved abuse or neglect. He explained he relied on the DON to complete investigations of the clinical aspects of incidents and accidents. He verified the resident fell on [DATE], when the CNA who was assigned to supervise residents who were identified as at risk for falls, left the room. The DON interjected that the housekeeper was in the activity room cleaning after the CNA left. The Administrator and the DON confirmed the housekeeper was not responsible for supervising residents, and her statement did not indicate she was watching them at the time. The Administrator stated after IDT discussions of resident #4's falls on 12/22/24 and 1/01/25, the facility determined the care plan was followed, therefore it was not reported as potential neglect. He checked the resident's care plans and verified although the DON determined resident #4 required increased supervision in the activity room, the care plans did not reflect this care need. The Administrator acknowledged the IDT did not identify the possibility of an inappropriate or ineffective plan of care during the investigation. On 2/15/25 at 2:07 PM, the Administrator stated he reviewed the fall investigations again and confirmed he could now see that there was not enough detail in some statements and he relied heavily on the DON's investigative findings regarding resident #4's care needs and care plan interventions. He explained as Risk Manager, he should have asked hard questions to ensure the incidents did not meet reporting criteria. The Administrator verified the purpose of a thorough investigation was to identify accurate root causes of incidents and accidents to ensure the facility developed and implemented interventions and processes that prevented recurrence and kept residents safe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2025
NAME OF PROVIDER OR SUPPLIER Savannah Cove		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to provide adequate assistance with activities of living (ADL) care related to fingernail care, oral care, and dressing for 3 of 4 residents reviewed for ADL care, of a total sample of 8 residents, (#1, #2, and #5). Findings: 1. Review of the medical record revealed resident #2, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included dementia, altered mental status, generalized muscle weakness, and lack of coordination. The Minimum Data Set (MDS) Admission assessment with assessment reference date (ARD) of 1/20/25 revealed resident #2 had unclear speech, was rarely or never understood, and rarely or never understood verbal content. Her Brief Interview for Mental Status (BIMS) score was 0/15, which indicated she had severe cognitive impairment. The MDS assessment showed resident #2 did not reject evaluation or care that was necessary to achieve her goals for health and well-being, and she was dependent on staff for assistance to maintain personal hygiene. Review of the medical record revealed resident #2 had a care plan, initiated on 1/15/25, for self-care deficits related to decreased mobility and weakness, the document indicated the resident required assistance with ADLs and the goal was her ADL care needs would be met. The interventions instructed nursing staff to assist with personal hygiene needs daily and assist to the shower twice weekly. Review of nursing progress notes for January and February 2025 revealed no documentation of refusals of care or the need to re-approach resident #2 to perform daily ADL care tasks. Review of skin evaluations completed by nurses in February 2025 revealed no documentation of the condition of resident #2's fingernails. On 2/14/25 at 10:26 AM, observation of resident #2's hands revealed all fingernails were approximately one-third inch long, uneven, and had sharp edges. There was a brown substance packed tightly under some nails, and others had a thick, gray, wax-like substance. The Activities Assistant inspected the resident's fingernails and confirmed all were very dirty. She verified the thumb nails were much longer than the others, and both had a thick layer of a substance she could not identify underneath them. On 2/14/25 at 10:32 AM, Certified Nursing Assistant (CNA) O checked resident #2's fingernails and verified they were too long and very dirty. He looked closely and confirmed there was a large amount of debris wedged underneath the fingernails. CNA O stated to his knowledge, resident #2 did not refuse ADL care. He explained residents were supposed to receive nail care at least twice weekly when they had a bath or shower, and whenever necessary in between those days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the medical record revealed resident #5, an [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included Rhabdomyolysis (a breakdown of muscle tissue that causes the release of harmful substances into the bloodstream), elevated white blood cell count, moderate protein-calorie malnutrition, repeated falls, and adult failure to thrive. Review of the MDS Quarterly assessment with ARD of 12/17/24 revealed resident #5 had clear speech, made herself understood, and had no comprehension issues. Her BIMS score was 15/15 which indicated she was cognitively intact. The MDS assessment showed resident #5 displayed no behavioral symptoms and did not reject care. Resident #5 required substantial or maximal assistance from staff to perform and maintain personal hygiene. Resident #5 had a care plan, initiated on 9/12/24, for self-care deficits related to decreased mobility and weakness. The document indicated the resident required assistance with ADLs and the goal was her ADL care needs would be met. The interventions instructed nursing staff to assist with personal hygiene needs daily and assist to the shower twice weekly. Review of nursing progress notes for January and February 2025 revealed no documentation of resident #5 refusing ADL care. On 2/14/25 at 10:50 AM, resident #5's fingernails were long, dirty, and not neatly shaped. The resident stated her fingernails had not been cut or filed since she was admitted to the facility. She said, This is the longest they have ever been in my life. I don't think they do that here. When informed fingernail care was to be done by nursing staff, she explained she didn't ask as she did not want to bother anyone. CNA N interjected and informed the resident that only licensed nurses were allowed to cut residents' fingernails. 3. Review of the medical record revealed resident #1, an [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included metabolic encephalopathy (brain dysfunction caused by an underlying condition), Alzheimer's disease, altered mental status, dementia with behavioral disturbance, lack of coordination, and generalized muscle weakness. The MDS Quarterly assessment with ARD of 12/20/24 revealed resident #1 had unclear speech, sometimes made herself understood, and sometimes understood others. Her BIMS score was 1/15 which indicated she had severe cognitive impairment. The document showed she exhibited acute onset mental status changes including fluctuating inattention, disorganized thinking, and altered level of consciousness that varied in severity. The MDS assessment revealed resident #1 did not reject evaluation or care that was necessary to achieve her goals for health and well-being. Resident #1 had a care plan initiated on 7/10/24 for self-care deficit related to Alzheimer's dementia with cognitive deficits and behavioral disturbance, decreased mobility, and weakness, for which she required assistance with ADLs. The goal was resident #1's ADL care needs would be met. The interventions instructed nursing staff to assist with bathing and dressing as needed, assist with personal hygiene needs daily, assist with oral hygiene at least twice daily and as needed, and utilize personal clothing protectors at mealtimes. Review of nursing progress notes for January and February 2025 revealed no documentation of resident #1 refusing ADL care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2025
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 10:29 AM, resident #1 was seated in her wheelchair in the facility's activity room. She had an unkempt appearance with messy hair and chipped dark red fingernail polish. There was evidence of smeared food and liquid on both pant legs, with the right thigh and knee area more soiled than the left. Resident #1 had very poor oral hygiene. Her upper and lower teeth had plaque and there was mucous attached to her tongue from her teeth. There was a significant amount of food particles in the resident's oral cavity, visible on the surfaces of her lower teeth, tongue, and inner lower lip. On 2/14/25 at 10:35 AM, CNA O stated he brushed resident #1's teeth two days ago, when he was assigned to care for her. He applied clean gloves, checked her mouth, and stated there was food present in her mouth, probably left over from breakfast. He confirmed her clothing was soiled with a food spill on her pants. CNA O said, She is a messy eater, but that is no excuse. He explained the assigned CNA should have taken resident #2 to the bathroom after breakfast, provided her with oral care, and changed her pants. On 2/15/25 at 12:14 PM, the Director of Nursing (DON) discussed the ADL concerns identified for residents #1, #2, and #5. She stated CNAs were responsible for completing all personal hygiene tasks for residents who could not do so for themselves. She explained licensed nurses should observe residents' ADL status in all daily interactions including when they administered medication, and also during weekly skin checks. The DON verified nurses supervised CNAs and they could direct any necessary care that was not given. She stated nail care should be done at least twice weekly with bed baths and showers, and mouth care should be performed at least twice daily. Review of the job description for Certified Nursing Assistant, dated 2/02/08, revealed he/she would provide superior quality care for residents by assisting with ADLs including personal hygiene and grooming tasks such as hair care, mouth care, nail care, and dressing. The facility's policy and procedure for Supporting Activities of Daily Living (ADL), dated March 2018, read, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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	105886	A. Building B. Wing	02/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on interview, and record review, the facility failed to provide adequate supervision to prevent falls and fall-related injury for 1 of 4 residents reviewed for fall risk, of a total sample of 8 residents, (#4). The facility's failure to appropriately monitor residents with cognitive and/or physical impairments resulted in actual harm for resident #4, and placed all residents who required increased supervision at risk for injury. Resident #4, a physically and cognitively impaired resident, received blood thinner medication and had a history of repeated falls. On 12/22/24, the Certified Nursing Assistant (CNA) assigned to supervise residents in the fall prevention program in the activity room left the residents unattended, and resident #4 fell from her wheelchair to the floor. Ten days later, another CNA left the resident alone in the activity room and she had another unwitnessed fall from the wheelchair. Assigned nurses neither initiated neurological checks nor notified the physician until almost 12 hours after the fall when staff discovered the resident had a bruise and a golf ball sized hematoma on her forehead. The resident suffered pain and anxiety, and required transfer to the hospital for diagnostic testing to rule out a brain bleed. Findings: Cross reference F600. Review of the medical record revealed resident #4, a [AGE] year-old female, was admitted to the facility on [DATE]. Her diagnoses included atrial fibrillation, stroke, lack of coordination, repeated falls, generalized muscle weakness, unsteadiness on her feet, right knee contracture, anxiety disorder, paranoid schizophrenia, and Alzheimer's disease. Review of the Minimum Data Set (MDS) Quarterly assessment with assessment reference date of 10/16/24 revealed resident #4 had a Brief Interview for Mental Status score of 6/15 which indicated she had severe cognitive impairment. The document indicated she had fluctuating inattention which changed in severity, and continuously present disorganized thinking. The resident had functional limitation in range of motion with impairment of one leg, used a wheelchair for mobility, and required substantial or maximal assistance for self-care and mobility. The MDS assessment showed resident #4 received a high-risk drug, an anticoagulant or blood thinner, in the look back period. A Fall Risk Screen dated 9/16/24 revealed a score of 16 which indicated resident #4 was at high risk for falls. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #4's medical record revealed a care plan for fall risk, initiated on 2/07/23, indicated she was unable to ambulate or transfer independently and had fall risk factors including decreased mobility, weakness, psychiatric medications, and cognitive deficits. The care plan revealed she fell at least four times between July and December 2024. The document was updated on 12/18/24 to reflect a fall without injury when she attempted to go to the bathroom. A revision dated 12/23/24 revealed the resident slid from her wheelchair onto the floor and did not sustain any injuries. The goal was resident #4 would not sustain a major fall-related injury by utilizing fall precautions as evidenced by observation and documentation. Interventions included participation in the fall risk program, non-slip pad for the wheelchair seat, remind to ask for help but recognize that the resident might not remember to ask, and escort to activity programs. A care plan for impaired mobility, initiated on 2/22/24, revealed resident #4 required ongoing assistance with mobility. The goal was she she would be out of bed daily in her wheelchair and transfer with assistance from one staff member. Review of a care plan for cognition, initiated on 2/22/24, revealed the resident's confusion and a language barrier affected her comprehension. Interventions included provide a safe and structured environment. Review of an incident report dated 12/22/24 at 1:45 PM revealed resident #4 fell to the floor from her wheelchair in the activity room. The document indicated she was uninjured and staff assisted her back to the wheelchair. Review of staff statements obtained during the incident investigation revealed resident #4 was one of a group of residents in the facility's activity room. The residents were supposed to be under direct supervision of an assigned CNA, who explained she left the residents in the room to attend to another resident who needed a shower. Statements from both Registered Nurses (RNs) on schedule revealed resident #4 was found on the floor with her coloring book nearby. A Post Fall Evaluation dated 1/01/25 at 11:30 PM, revealed ten days later, resident #4 fell in the facility's activity room at 10:30 PM. The document indicated the unwitnessed fall occurred because she was unattended in activity room. RN M's documentation revealed she instructed CNAs three times to not leave the resident unattended. She wrote, Resident left unattended in activity room, while I was giving report to [Emergency Medical Services]to send another resident to the hospital due to critical abnormal labs. The document indicated a hematoma was noted on resident #4's head the following day, on 1/02/25. Review of resident #4's Physician Orders revealed on 12/02/24, her physician prescribed Warfarin Sodium 6 milligrams once daily at 5:00 PM. There was an order dated 1/02/25 to transfer her to the hospital for ecchymosis or bruising and a hematoma on her forehead after a fall. Warfarin is an anticoagulant or blood thinner drug that reduces the formation of blood clots and can cause major or fatal bleeding. The manufacturer's instructions to providers indicate the use of Warfarin for geriatric patients, particularly those with cognitive issues, requires more frequent monitoring for bleeding in any situation or with any physical condition where added risk of hemorrhage is present (retrieved on 2/19/25 from www.drugs.com/pro/warfarin.html). A hematoma is a raised, bruised area resulting from a collection of clotted blood due to an injury or trauma (retrieved on 2/19/25 from www.my.clevelandclinic.org/health/diseases/15235-bruises). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2025
NAME OF PROVIDER OR SUPPLIER Savannah Cove		STREET ADDRESS, CITY, STATE, ZIP CODE 1301 W Maitland Blvd Maitland, FL 32751	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Falls can cause very serious head injuries, especially if the person is taking blood thinners. Older persons who fall and hit their heads should see a physician immediately to ensure they do not have a brain injury (retrieved on 2/20/25 from www.cdc.gov/falls/data-research/facts-stats/). Review of the Resident Transfer Form dated 1/02/25 revealed resident #4's diagnoses at the time of her transfer to the hospital were fall, blood thinners, and dementia. The document showed the resident had an injury to the left side of her forehead. Resident #4's hospital record revealed a computed tomography (CT) scan of her head, done on 1/02/25, found no hemorrhage or skull fractures, but showed soft tissue swelling in the left frontal scalp. On 2/14/24 at 10:42 AM, resident #4's daughter stated her mother fell in the activity room a little over a month ago. She explained it was a scary incident as her mother was on blood thinners and hit her head when she fell . She recalled her mother's face was badly bruised for a while. The resident's daughter said, Thanks to God she didn't have a serious injury inside her head. At the hospital they told me since she was on [Warfarin], she should get checked out there after a fall. She stated the facility informed her the CNA who was with her mother got up and left her alone in the activity room. On 2/14/25 at 3:52 PM, RN M described resident #4 is a well-known fall risk who needed staff supervision, sometimes one-to-one, to ensure she did not crawl out of bed or slide out of her wheelchair. She recalled the resident was agitated on the night of 1/01/25, so she asked CNAs to keep her in a common area and monitor her closely. RN M stated while she attended to another resident in a crisis situation, she repeatedly looked towards the nurses' station where resident #4 sat in her wheelchair, and repeatedly instructed the CNAs to ensure someone stayed with her. RN M stated a little later she was in the hallway and heard a moan from the activity room. She explained she discovered the resident on the floor, parallel to her wheelchair, and there was no CNA present in the room. RN M stated she assessed resident #4 and noted no injuries, so staff returned her to the wheelchair. She stated there were no new fall prevention interventions for this resident, and residents at risk for falls were placed in the activity room with CNAs rotating through the room to watch them. She explained the facility did not always have enough staff to monitor residents who needed more supervision. On 2/15/25 at 9:14 AM, the Director of Rehabilitation (Rehab) confirmed resident #4 had cognitive issues and required close monitoring to promote her safety. She reviewed an Occupational Therapy Evaluation completed on 11/22/24 which indicated the resident was at risk for falls due to impaired safety awareness and decision-making. The Director of Rehab explained resident #4 was not able to stand and transfer without moderate assistance from one person, and if she was not inclined to cooperate, it might be necessary for two people to assist for safety reasons. The Director of Rehab said, She is impulsive and thinks she can do stuff. She stated the interdisciplinary team spoke about a reacher after the fall in January 2025 as a possible intervention to prevent falls. She explained due to the resident's poor cognition, she probably would not use a reacher effectively. She verified falls were a leading cause of injuries for the elderly, and stated some falls could be prevented if residents could be educated and followed commands. The Director of Rehab acknowledged supervision was the most important approach to keep resident #4 and other cognitively impaired residents safe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2025

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 2/14/25 at 12:24 PM and 1:30 PM, the Director of Nursing (DON) discussed resident #4's recent falls in the activity room. She explained on 12/22/24, the resident slid from her wheelchair when she reached to pick up coloring items that fell to the floor. She stated the care plan was revised to include a a non-slip pad for her wheelchair to prevent her from sliding. However, the DON acknowledged the exact circumstances of the fall were unknown as it was unwitnessed. She verified the resident fell when the CNA assigned to ensure the safety of residents in the fall prevention program left the room. Although resident #4's fall occurred when she was not supervised, the care plan was not updated to reflect her need for supervision, and the DON maintained a non-slip pad was an appropriate intervention for that circumstance. The DON stated after the resident's fall on 1/01/25, she asked the therapy department to re-evaluate her for wheelchair positioning and a reacher device. She confirmed the resident's fall occurred after a CNA again left her alone in the activity room. The DON verified although the CNA should not have left the resident unattended, and nursing documentation revealed she needed close monitoring, the care plan was not revised to show she required increased supervision. She reiterated the interventions related to assessing the resident for proper positioning in the wheelchair and use of a reacher were appropriate Review of the facility's Falls-Clinical Protocols, revised in March 2018, revealed the physician would identify medical conditions affecting fall risk including cognitive impairment and musculoskeletal abnormalities, and note the risk for significant complications of falls such as an increased risk for bleeding in residents who took anticoagulants. The document indicated staff and the physician would attempt to identify underlying causes, develop pertinent interventions to try to prevent subsequent falls, and monitor the effectiveness of the approaches.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36489 Based on observation, interview, and record review, the facility failed to maintain sufficient staff to provide adequate supervision and meet care needs to ensure the safety and well-being, according to the plans of care, for all residents of the facility. Findings: Review of the Facility assessment dated [DATE] revealed the facility had 39 licensed beds and the average daily census over the previous three months was 32 residents. The document indicated the facility was able to meet the needs of residents with common diseases, conditions, and physical and cognitive disabilities such as impaired cognition, anxiety disorder, behavior that required intervention, Alzheimer's disease, muscle weakness, and a history of falling. At the time the Facility Assessment was completed, the census was 30 residents and approximately 50% of the residents were totally dependent on staff for assistance with dressing, transfers, toileting, and mobility. The document indicated one resident was independent for mobility and two residents were independent for toileting and transfers. All other residents required the assistance of one to two staff for transfers, toileting, and mobility, and there were no residents who were independent with all activities of daily living. The Facility Assessment revealed staff would provide support to meet care needs for mobility and prevention of falls or falls with injury by assisting with transfers and activity programming, and provide person-centered care by identifying hazards and risks. On 2/14/25 between 10:20 AM and 10:40 AM, during tour of the facility, Certified Nursing Assistants (CNAs) entered and exited residents' rooms to provide care. All staff appeared rushed as they went from room to room and did not pause to interact with residents in the hallways or common areas. Multiple call lights were observed, with an average staff response time of approximately five minutes. CNAs entered the rooms, turned off call lights, and exited almost immediately to continue their rounds. Review of the staffing board revealed the census was 33 residents and there were two nurses and three CNAs working. On 2/14/25 at 10:58 AM, the Administrator stated the facility was usually staffed with three to four CNAs on the day and evening shifts, and two to three CNAs on the night shift, depending on the census. He explained the facility has always exceeded the State minimum requirements for staffing. On 2/15/25 at 9:40 AM, during tour of the facility, as CNAs gave care to residents, they appeared hurried as they rushed from task to task and the call light response time was greater than five minutes. Call lights in two rooms were turned off by staff who immediately exited the rooms, and were quickly pressed again by residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/14/25 at 3:52 PM, Registered Nurse (RN) M explained resident #4 was at high risk for falls and staff would often need to initiate one-to-one supervision to ensure her safety. She stated there were currently several residents who were at risk for falling, and the high acuity care needs sometimes created dangerous situations. When asked if the facility maintained adequate staff, she said, Staffing is definitely a concern. I have brought it up to the DON [Director of Nursing] and Administrator. RN M explained insufficient staffing was not an isolated thing and even if four CNAs were scheduled, when one called off, as happened yesterday, there were only three CNAs left to meet the residents' needs. RN M explained nursing staff determined that in addition to residents who required increased supervision, almost two-thirds of the residents required two-person assistance for safety or care. She confirmed the facility's fall prevention program involved CNAs who had resident care assignments doing 1-hour rotations to sit in the activity room with residents at risk for falls. RN M explained staff were busy during the evening shift and there are not always enough staff to watch the residents who needed more supervision. On 2/14/25 at 4:27 PM, CNA F was seated in the activity room with eight residents. She explained she was doing her 1-hour rotation in the room until 5:00 PM. She confirmed she was currently assigned to care for 11 residents, but only one person in the activity room was on her assignment. When asked who provided care for her residents while she did rotations in the activity room, she stated other CNAs answered her residents' call lights, if they were not busy. CNA F said, But I cannot really say if they are changing anyone. If I have showers scheduled, they have to wait. To change some people that use a [mechanical lift], it takes two people to put them back to bed and into the chair again. That means it can't always be done. On 2/14/25 at 4:34 PM, CNA E confirmed all CNAs were required to take turns in the activity room to provide one-to-one care for residents at risk for falls. She explained when there were only three CNAs scheduled, it was difficult to complete all required tasks for the shift. She said, One person sitting in the room leaves only two on the floor. Everybody is busy and it's hard to take care of your people and another assignment too. If I am watching someone's assignment, I can't do showers or anything that will take a lot of time. If I do, then that leaves only one CNA on the floor. On 2/14/25 at 4:48 PM, CNA D confirmed she had to sit with residents in the activity room for one hour at a time. She explained the other CNAs on the unit answered call lights for the CNA assigned to the fall prevention program. She stated if there were only three CNAs scheduled, it was hard to give appropriate care to assigned residents. On 2/15/25 at 10:11 AM, CNA B verified she was required to do 1-hour rotations in the activity room although she was assigned to care for nine residents. She explained the facility was usually staffed with three CNAs and it was very hard to manage with that number of staff as many residents were at risk for falls. She said, You have to stop care and go sit for an hour. We have told the DON and Administrator and they know that it would be better with four. It would be better for us not to have to rotate. CNA B confirmed she was to expected to do rounds every two hours and some residents complained that they call and CNAs do not get to them timely. On 2/15/25 at 10:28 AM, Licensed Practical Nurse (LPN H) acknowledged nursing staff were supposed to closely monitor residents at risk for falls. She explained nurses tried to assist CNAs by responding to call lights during the time they were assigned to the activity room. She stated she was sure the CNAs could be overwhelmed and it did not seem like an optimal care situation. LPN H said, I have to help CNAs, but I have my job. I feel like we could absolutely improve on staffing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105886	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2025

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/15/25 at 10:46 AM, CNA O hesitated when informed he was to be interviewed by State Survey Agency staff. He asked how long the interview would take as he had to return to his assigned residents to provide activities of daily living care and did not have much time. CNA O verified he took turns with other CNAs to rotate through the activity room when activities were not there. He stated the other CNAs covered his assignment during the time he was off the floor. CNA O said, It would be preferable to have an assigned CNA in that room. On 2/15/25 at 11:00 AM, CNA L, stated she was assigned to care for 11 residents including five who were totally dependent and others who were at risk for falls. She said, To be honest, I am not giving the best care possible to my residents as I can't leave the fall risks in the activity room. She explained if her assigned residents needed care, the other CNAs or nurses could respond to call lights. She confirmed the residents who did not use the call light would have to wait until she was finished with her hour-long activity room rotation. CNA L stated the facility's Administrator and DON were aware of how difficult it was for staff to do the one-to-one rotation. She stated staff informed the members of facility management that they needed additional help in the form of an extra CNA. CNA L said, We were told by the person who did scheduling that the facility has to go by numbers and it depends on the census. On 2/15/25 at 11:15 AM, CNA A stated residents who were agitated and/or at risk for fall risks posed a challenge on the days when the facility did not have enough staff. She explained CNAs sometimes resorted to putting residents in wheelchairs and taking them along as they worked or placing them beside the nurse. On 2/15/25 at 2:53 PM, CNA G stated she felt the facility was usually understaffed, especially on the 3:00 PM to 11:00 PM shift. She explained if there was a call off, there would usually only be two CNAs in the facility. She said, Imagine what that is like. Watching the people who fall and with more than 15 residents each. She added that there were many residents who required assistance from two staff as they transferred with a mechanical lift and it was almost impossible to get help if the other CNA is in the activity room. CNA G said, It is not fair. Staffing is horrible. They must be trying to save money. On 2/15/25 at 1:57 PM, CNA C explained the requirement to supervise the residents at risk for falls in the activity room took up at least two and sometimes three hours out of her 8-hour shift. She said, It absolutely gets in the way of caring for my residents. We have to take 1-hour turns and we get overloaded. We get angry because we can't do our own job. They need someone in the room. She explained CNAs were so behind on their work by the end of the shift that they could not leave on time. CNA C stated she often continued to work with patients and chart after shift change report. She verified the facility used to schedule four CNAs for days and evenings, but recently it is usually three CNAs. On 2/15/25 at 2:44 PM, CNA I stated CNAs had to do rotations in the activity room to monitor up to ten residents who were at risk for falls. She described feeling burnt out and physically exhausted when she got home due to the demands of the job. CNA I said, It is supposed to be one-to-one, but it is really one CNA to seven or more. Staff have told them it isn't good. You are like a prisoner in that room, looking out while your own residents are not getting the right care. Yes, someone might answer the call lights, but they are not doing everything else in the line of giving care. (continued on next page)

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	105886	A. Building B. Wing	02/15/2025

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/15/25 at 12:04 PM and 12:20 PM, the Administrator and DON stated they were not aware staff were overwhelmed and had concerns related to not being able to meet residents' care needs, nor that staffing ratios were a problem due to the requirement for CNAs to leave their assigned residents and sit in the activity room for one hour rotations. He explained activity department staff also assisted with supervision of residents in the fall prevention program. He was informed interviews with activities staff revealed they were not aware of which residents in the room required close supervision. The Administrator stated activities staff assisted from about 9:00 AM until lunchtime and then returned by 1:30 PM and stayed until about 3:00 PM. He stated after activities staff left the room, nurses were expected to jump in and assist call lights and sitting with residents. He acknowledged nurses had assignments of 15 to 20 residents. The Administrator confirmed staffing fluctuated with the census but acknowledged it should also reflect residents' needs. The DON confirmed a significant number of the facility's residents had dementia and exhibited the confusion, agitation, restlessness typical of sundowning behavior associated with this diagnosis. She explained the behaviors usually started in the evening at about 5:00 PM and could continue for hours. The Administrator acknowledged in light of increased behaviors on the 3:00 PM to 11:00 PM shift, the absence of activities staff after 3:00 PM was not helpful to staff caring for this population. On 2/15/25 at 12:52 PM, the facility's Staffing Coordinator stated she was responsible for determining how many nurses and CNAs were scheduled for each shift, in conjunction with the Administrator and DON. She explained she utilized the census to schedule staff according to the number of residents in the facility. As an example, the Staffing Coordinator stated for the current census of 33, she was allowed to schedule no more than three CNAs for the day and evening shifts. She explained she needed approval from administration to schedule four CNAs. The Staffing Coordinator verified CNAs and nurses had complained to her regarding the difficulties of supervising the residents in the fall prevention program while caring for their assigned residents. She confirmed she relayed staff concerns to the Administrator and DON more than once, but they reminded me of the numbers related to the census. The Staffing Coordinator stated she reported their response to staff, .that we can only have a certain amount of staff based on census. She stated she as not aware there was no maximum limit for staffing or that staffing should reflect the different levels of care and supervisions necessary to meet residents' needs. She acknowledged staff workload and patient care would be much better with four CNAs, but she was not usually able to do that unless there were at least 35 or 36 residents. The Staffing Coordinator stated she noticed that after dinnertime, some of the residents got more agitated and it took up the CNAs' time to sit with them, watch, or keep checking while they put other residents to bed and assisted with showers. The Staffing Coordinator validated CNAs were accurate when they claimed there had been a change in staffing ratios in the last few months. She explained since a recent change of ownership, the facility now placed more of an emphasis on staffing according to the census.