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	09/19/2024

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on observation, interview, and record review, the facility failed to request a Preadmission Screening and Resident Review (PASARR) Level I Screen with a new mental disorder diagnosis for 2 of 3 residents reviewed for PASARR, of a total sample of 30 residents, (#24, and #14). Findings: 1. Resident #24 was admitted to the facility from an acute care hospital on 11/21/22 with diagnoses that included acute kidney failure, and type II diabetes. She was later diagnosed with dementia that included mood disturbances and in February of 2024 she was diagnosed with major depressive disorder that was moderate and recurrent. The Minimum Data Set (MDS) Quarterly assessment dated [DATE], revealed resident #24 was moderately impaired cognitively, non-verbal and required substantial assistance for all activities of daily living (ADLs). The assessment further revealed she was unable to focus on tasks and had disorganized thinking. Review of the medical record revealed an updated Level I PASARR screen had not been completed for resident #24 after receiving the new diagnoses. Resident #24's active physician orders revealed she was taking Trazodone at bedtime for depression and was being monitored for targeted behaviors such as restlessness, agitation, and lack of appetite. A care plan for resident #24 dated 11/29/23 noted she had ongoing behaviors such as refusals of care and medications. The care plan indicated her behaviors were complicated by the diagnosis of dementia with cognitive deficits, and a short attention span during tasks. On 09/16/24 at 3:00 PM, resident #24 was observed during an activity in the resident lounge. Her behavior was withdrawn and confused while staff attempted to interact with her. Resident #24's medical record revealed on 2/02/24 she was referred for a psychological evaluation due to symptoms related to depressive disorder. The note stated the staff described resident #24 was irritable at times and withdrawn. A recommendation was made for the resident to continue taking medications only, as psychotherapy would not have been beneficial due to resident being nonverbal. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 5:40 PM, the Director of Nursing (DON) confirmed she was responsible for submitting the PASARRs. She said resident #24 had been in the facility for 2 years and had a new diagnosis of depression. She said she was not aware a new Level I PASARR had to be submitted for resident #24. 50875 2. Review of the medical record revealed resident #14 was admitted to the facility on [DATE] and readmitted on [DATE] from the hospital. Her diagnoses included chronic pain, major depressive disorder, generalized anxiety disorder, and heart failure. Resident #14 received a new diagnosis of bipolar disorder in February of 2024. Resident # 14's Annual MDS assessment with assessment reference date of 8/30/24 revealed the resident scored 11 out of 15 on the Brief Interview for Mental Status which indicated she had moderate cognitive impairment. The assessment indicated she had feelings of depression with no hallucinations, delusions nor refusal of care. Review of resident #14's medical record showed a care plan dated 3/28/24, which indicated the resident was followed by psychiatric services. She was seen by a Licensed Clinical Social Worker and a Psychiatrist with interventions that included psychiatric medications administered as ordered and the physician to be notified for change in mood /depression or change in cognition. Resident #14 also had a Care Plan dated 3/28/24 for psychiatric medication use related to depressive disorder, anxiety and bipolar disorder. The Care Plan was updated on 9/13/24 and indicated resident #14's problem/risk was ongoing and she was seen by the Psychiatrist with interventions that included psychiatric evaluations and treatment as needed, monitor for mood/behavior and document every shift for abnormalities. Resident #14's monthly psychiatry notes dated from 2/20/24 to 8/19/24 all revealed within the treatment plan that the resident was treated with Abilify 5 milligrams (mg) for bipolar disorder, yet bipolar disorder was never included in the Level I PASARR as a new diagnosis. There were no psychiatric notes for the month of September 2024. On 9/19/24 at 3:28 PM, the DON was asked for the most recent Level I PASARR for resident #14 and she presented the Level I PASARR dated 10/26/20. She verified that anxiety and depressive disorders were listed on the PASARR and confirmed the new diagnosis of bipolar disorder was added in February of 2024. The DON confirmed the diagnosis should have been updated on a new Level I PASARR. She acknowledged she was responsible for updating PASARRs and confirmed resident #14 should have had an updated Level I PASARR with the new diagnosis of bipolar disorder listed. She stated the facility did not have a policy on PASARRs.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875 Based on interview and record review, the facility failed to request a Preadmission Screening and Resident Review (PASARR) level I and level II evaluation for 1 of 3 residents reviewed for PASARR, of a total sample of 30 residents, (#25). Review of the medical record revealed resident #25 was admitted on [DATE] from the hospital. Her diagnoses included vascular dementia, Alzheimer's disease, major depressive disorder and generalized anxiety disorder. Resident #25's Admission Minimum Data Set (MDS) with an assessment reference date of 7/31/24 revealed the resident was admitted to the facility with Alzheimer's dementia, anxiety disorder and psychotic disorder (other than schizophrenia) and she received antipsychotic and antidepressant medications. The MDS also revealed the resident had severely impaired cognitive skills for daily decision making and did not have any behaviors during the lookback period. On 9/17/24 at 11:32 AM, the Director of Nursing (DON), could not locate resident #25's Level I PASARR in the medical record. She later confirmed it was not in the social services tab nor anywhere else in the resident's chart. On 9/18/24 at 9:41 AM, the DON stated the resident came from out of state and would have had a Level I PASARR done initially. Both the DON and the Administrator confirmed they made calls to find out why the Level I PASARR was not in the chart and determined it was probably lost or misplaced, but they could not confirm if it was ever there in the first place. They both agreed resident #25 should have had a Level I PASARR filled out prior to admission and placed in her chart. On 9/19/24 at 3:28 PM, the DON acknowledged she was the one responsible for updating PASARR. She stated the facility did not have a policy on PASSARs.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875 Based on observation, interview, and record review, the facility failed to obtain physician orders before administering oxygen therapy, and failed to maintain oxygen flow rates as ordered by the physician for 2 of 3 residents reviewed for respiratory care, of a total sample of 30 residents, (#12 & #29). Findings: 1. Resident #12 was readmitted to the facility on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (COPD), shortness of breath, dependence on supplemental oxygen and heart disease. Review of the Admission Minimum Data Set (MDS) assessment with reference date 9/06/24, revealed resident #12 was cognitively intact, had no behaviors, nor refused care, and required the use of oxygen. Resident #12 was also visually impaired, required assistance with activities of daily living and used a wheelchair for mobility. Review of resident #12's physician orders for continuous oxygen was 1 liter (L) per minute (min) via nasal cannula. Resident #12 had a Respiratory Care Plan related to Covid-19 pandemic due to shortness of breath and a history of COPD, asthma, prior stays with oxygen and medication use. Interventions included licensed nurse to monitor oxygen saturations as ordered and to administer oxygen as ordered. On 9/16/24 at 11:46 AM, resident #12 was observed in bed with dark sunglasses on. She wore a nasal cannula connected to an oxygen concentrator with an attached humidifier. Observation of the oxygen concentrator showed it was set at 4 L of oxygen per minute and the oxygen tubing was not dated. Resident #12 stated she did not know how many liters of oxygen she needed nor the number the concentrator was set at. On 9/17/24 at 1:33 PM, resident #12 was observed in bed with her nasal cannula attached to the portable oxygen tank behind her wheelchair. She said she was waiting on the nurse to connect her oxygen back to the concentrator. The oxygen flow rate was observed at 3 L/min. A few minutes later in the hall, assigned Licensed Practical Nurse (LPN) B, stated she verified the physician orders at the beginning of her shift. LPN B was accompanied to resident #12's room where she confirmed the flow rate on the oxygen tank was set at 3 L/min. LPN B proceeded to connect the nasal cannula to the humidified oxygen concentrator now set at 3 L/min. A few minutes later outside resident #12's room, LPN B was asked to verify the physician orders in the electronic record. She stated the physician order was for 1 L /min of continuous oxygen. LPN A, the Desk Nurse on duty, also verified the most current order was for continuous oxygen via nasal cannula at 1 L/min. She explained oxygen tubing was changed and dated every Saturday. LPN B again confirmed resident #12 was not on the physician ordered flow rate of oxygen and proceeded to resident #12's room to correct it. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Treatment Administration Record for September 2024 showed that although there was an order for continuous oxygen delivery, there were no orders for nurses to change the oxygen tubing for resident #12. On 9/18/24 at 10:06 AM, the Director of Nursing stated for residents on oxygen, it was the responsibility of the nurses to verify the orders and adjust the oxygen flow rates according to the physician orders at the beginning of their shift. She confirmed resident #12's nurses had not done what they were supposed to and should have validated the amount of oxygen given per the physician order. Review of the Quality of Care- Respiratory/Tracheostomy Care and Suctioning Policy with revision date January 2023 revealed the intent was each resident received the necessary respiratory care and services in accordance with professional standards of practice, the resident's care plan and the resident's choice. 49840 2. Resident #29 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage 3, prostate cancer, and muscle weakness. The Quarterly MDS dated [DATE], revealed resident #29's cognition was moderately impaired, and he required substantial to moderate assistance for activities of daily living. On 9/16/24 at 11:00 AM, resident #29 was observed in bed with eyes closed. He had continuous oxygen via nasal cannula attached to an oxygen concentrator set at 2 liters per minute. Review of the medical record on 9/16/24 revealed resident #29 had no active orders for oxygen therapy. Review of a physician's note dated 9/16/24 revealed resident #29 had no changes in condition, no respiratory decline, and there were no new orders. On 9/17/24 at 5:45 PM, Registered Nurse (RN) G stated she was new to the facility and was unsure when resident #29 received an order for oxygen. She said during morning rounds she would check the oxygen orders and compare them to what the tank was set to. She was unable to find the oxygen orders in the electronic medical record. The nurse checked the paper chart and found an order for oxygen dated that day 9/17/24. The Director of Nursing (DON) came to assist RN G with finding the oxygen orders in the electronic record and confirmed a new order for continuous oxygen at 2 liters per minute via nasal cannula for shortness of breath starting on 09/17/24. She explained the resident was declining in health and the doctor had seen him that morning. Review of a physicians note in the electronic medical record revealed resident #29 was again seen by the attending physician on 9/17/24. She documented his oxygen saturation level (SpO2) was 98% on room air, he was comfortable and not in any acute distress. There were no new orders. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 1:11 PM, the Advanced Practice Registered Nurse stated she had seen resident #29 on 9/16/24 but she did not recall if he was on oxygen. She explained the resident's breathing was stable and had no changes in condition requiring oxygen therapy. It was her expectation that an order for oxygen would be obtained prior to the administration of oxygen to make sure the correct amount is being received. On 09/19/24 at 9:45 AM, the attending physician stated the resident did not have a decline in his oxygen saturation levels and could not remember the reason why he was on oxygen. She said she was aware she signed the verbal order for continuous oxygen at 2 L on 9/17/24, but stated the resident would do fine on room air and she could instead write the order for the resident to have oxygen as needed. She further stated it was her expectation for staff to obtain oxygen orders prior to the administration of oxygen to ensure residents received the correct amount. The facility provided an undated policy and procedure titled Respiratory/Tracheostomy Care and Suctioning which stated the purpose of the policy was to ensure each resident received necessary respiratory care and services in accordance with professional standards of practice, the resident's care plan, and the resident's choice.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840 Based on observation, and interview, the facility failed to ensure dry food items in the main pantry were properly stored by keeping track of expiration dates to prevent food-borne illnesses and failed to maintain a clean and sanitary environment in the unit refrigerator where resident's foods and bedtime snacks were kept. This noncompliance had the ability to affect 30 of 30 residents in the facility, who were able to eat. Findings: On [DATE] at 10:21 AM, during the tour of the kitchen pantry, a walk through the dry storage area revealed dry food packages that had been opened but had no opened date, expiration date, or discard date. These foods included an open soy sauce bottle that was dripping black colored liquid around the sides, an almost empty bag of crispy onions that was wrapped but had no date to indicate when it was opened, a half of a package of tortilla chips also wrapped but with no open date, a bag of dry mashed potato mix open with no date, three bags of tortilla wraps expired as of [DATE], and three large packages of taco shells, not opened but without the original packaging so the expiration date was unknown. The Food and Nutrition Manager, who oversaw the kitchen, explained he had just started working at the facility within the last three months and was still trying to organize the kitchen. He stated all kitchen staff were responsible for making sure food items were properly dated after they were opened to prevent pests and possible food-borne illness. On [DATE] at 2:20 PM, a tour was conducted of the resident pantry located on the unit inside the main dining room. There was a table used as a counter for serving food and under the table there were two large containers halfway full of dry cereal. Both containers were visibly dirty with a sticky brown substance on the lids. There was also an open bag of cereal wrapped in plastic wrap with no date to indicate when it was opened. The refrigerator had food items such as apple sauce, prune juice, fruit, peanut butter and jelly sandwiches, and three jugs of juice labeled cranberry, lemonade, and orange. The jug that contained the lemonade had a brown stain on the inside of the lid. On the top shelf there was a nutritional supplement bottle knocked over which had dripped all over the shelf. The stainless-steel container holding the peanut butter and jelly sandwiches was splattered with a sticky brown substance. At the bottom of the fridge there were two drawers dirty with a caked on brown substance. Kitchen Aide H was there during the tour and stated she cleaned the refrigerator once per week and as needed. She said it must have gotten dirty during the night shift and she only worked during the day. She acknowledged the refrigerator needed to be cleaned. On [DATE] at 3:00 PM, the Food and Nutrition Manager stated the refrigerator in the resident pantry was supposed to be cleaned once per week on Mondays. He said it was the expectation for all staff to clean the refrigerator if there were spills to maintain a clean and sanitary environment for the residents. Furthermore, he said the container of lemonade was stained because iced tea which was also kept in the refrigerator caused the white container to stain. He confirmed that any dry food items, such as dry cereals, needed to be labeled and stored in the main kitchen pantry and not under serving tables. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's policy and procedure for Food Handling dated ,d+[DATE], revealed it was the policy of the facility to procure, store, prepare, distribute, and serve food under sanitary conditions following proper sanitation and food handling practices to prevent the outbreak of foodborne illness in accordance with State and Federal Regulations. It further stated under procedure number 11 that food should be properly labeled and expired foods should be discarded.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50875 Based on observation, interview, and record review, facility staff failed to change gloves and perform hand hygiene, before moving from a contaminated-body site to a clean-body site during wound care, consistent with professional standards of practice, for 1 of 1 resident reviewed for pressure ulcers, of a total sample of 30 residents, (#25). Findings: Resident # 25 was admitted to the facility on [DATE] from the hospital. Her diagnoses included fracture of the left neck of the femur, Methicillin -resistant Staphylococcus aureus (MRSA) unspecified site, vascular dementia, Alzheimer's disease, and a pressure ulcer on right ankle. Resident #25's admission Minimum Data Set with an assessment reference date of 7/31/24 revealed the resident was admitted to the facility with an active diagnosis of an unstageable pressure ulcer of the sacral region. Other health conditions revealed her life expectancy was less than six months and received hospice care as indicated for special treatments. The medical record also revealed the presence of a pressure ulcer/injury scar, dressing, one or more unhealed pressure ulcers and skin and ulcer/injuries. Review of resident #25's medical record revealed a care plan initiated on 2/15/24 for further unavoidable pressure ulcer development due to clinical conditions. The goal was the wound would show evidence of healing and be free from infection with interventions where staff provided incontinence care as needed, treatment as ordered by physician, and weekly and as needed skin evaluations. Review of the most recent wound care note documented by the Wound Care Physician dated 9/16/24, showed the resident had wounds on her right ankle, right foot and sacrum. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/18/24 at 2:25 PM, wound care on resident #25 was observed with Registered Nurse (RN) C and Certified Nursing Assistant (CNA) E. After introductions and preparation for the treatment, they both washed their hands and donned clean gloves. RN C donned a mask and sanitized resident # 25's bedside table and placed a barrier drape on the table. She then assembled her supplies from the wound care treatment cart and together with CNA E, repositioned resident #25. Both RN C and CNA E then repositioned resident #25 so that RN C could provide wound care of the third site, the resident's sacrum. RN C then removed her gloves, washed her hands, donned new gloves and removed the old dressing. She then cleansed the site with gauze and normal saline. As RN C proceeded, she neither removed her dirty gloves nor washed her hands, instead, she reached into the prepared medication container with house barrier cream with the dirty gloves and applied it to resident #25's sacrum. She then applied a foam bordered dressing to the resident's sacrum with the date and her initials. Finally, RN C removed her gloves and washed her hands and proceeded to change the final dressing on the resident's right upper arm. RN C removed the used dressing from the resident's arm and she cleansed the area with normal saline but again did not remove her dirty gloves. She dipped her fingers into the same container of barrier cream previously contaminated by her dirty gloves and applied it to the resident's right upper arm then covered it with the dressing. After leaving resident #25's room, RN C acknowledged she should have discarded her used gloves, washed her hands and gotten new gloves (twice) before she applied clean treatments to the resident. She explained she should have not used the same dirty gloves to prevent the spread of infection. On 9/18/24 at 2:58 PM, the Director of Nursing stated gloves should be changed between every step in the wound care process and RN C should have changed her gloves and washed her hands before the application of barrier cream to the sacral wound and right upper arm skin tear of resident #25. A review of the facility's policy and procedure for Hand Hygiene, dated January 2023, read hand hygiene must be performed (even if gloves are used), before and after contact with the resident; after contact with objects in the resident's room; before performing aseptic task and after contact with blood, bodily fluids and or visibly contaminated surfaces.