Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11969117 | A. BUILDING: _____ B. WING _____ | 02/25/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MARKET STREET VIERA | 6845 MURRELL RD MELBOURNE, FL 32940 |

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| A 000 | Initial Comments<br><br>Complaint Investigation #2020020093 was conducted on . . . . . Market Street Viera had a deficiency identified at the time of visit. | A 000 | | |
| A 025 SS=G | 429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision<br><br>429.26<br>(7) The facility shall notify a licensed physician when a resident exhibits signs of . . . . . or . . . . . or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such . . . . . or . . . . . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making . . . . . for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition.<br><br>59A-36.007<br>An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.<br>(1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:<br>(a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. | A 025 | | |

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| A 025 | Continued From page 1<br><br>(b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident.<br>(c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.<br>(d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change.<br>(e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out.<br>(f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on records review and interview, the facility failed to ensure that a medication was administered as ordered, free from errors for 1 of 4 residents (#1), and failed to ensure that a special diet was served as ordered for 1 of 4 residents (#2).<br><br>Findings :<br><br>1. Adverse Incident Report dated indicated on [redacted] at approximately 9:30 PM, a Licensed Practical Nurse (LPN) inadvertently gave resident #1 [redacted] wax removal drops into his right [redacted] instead of routine bedtime [redacted]. The resident immediately stated that his [redacted] was [redacted]. The nurse assessed the | A 025 | | |

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| A 025 | Continued From page 2<br><br>situation and noticed the medication error. She flushed the right , a few times with sterile water in the , wash station located in the medication room. At approximately 10:15 PM, the executive director and Advanced Practice Registered Nurse were notified. Order was received for the resident to be sent to emergency room for evaluation. He was sent out via non-emergency transport at approximately 11:30 PM. He returned to the facility at 5:30 AM on . Upon return, he had , irritation with some redness to his right , .<br><br>Resident record review revealed an updated health assessment dated that listed visual , , hearing loss, , and . He needed administration of medications. Emergency room discharge instructions dated , indicated to see the docto if redness/irritation continues. Facility note dated at 5:20 AM indicated that at approximately 9:30 PM on inadvertently the nurser instilled wax removal drops into his right , instead of the routine , , . The resident immediately said, "Its , I can't see." The nurse assessed the situation and noticed the medication error; she flushed the , . PERLA (Pupils equal, reactive to light and accommodation) assessment done. Pupils were dilated and non- reactive. The Advance Practice Registered Nurse ordered to send the resident to the emergency room. He returned at 5:30 AM with diagnosis of , irritation.<br><br>On , the administrator said the nurse just picked up the wrong drops but realized quickly and took appropriate measures.<br><br>2. Adverse Incident Report dated | A 025 | | |

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| A 025 | Continued From page 3<br><br>indicated that on [redacted] at approximately 5 PM, resident #2 was served dinner. He had orders for a mechanical soft diet. He chose a roast beef sandwich. The Resident Care [redacted] (RCSs) served him the roast beef sandwich. At approximately 5:15 PM , the resident started to [redacted]. The Licensed Practical Nurse (LPN) assessed him. He seemed to be choking at first, but it was determined that he was able to breath. He continued to [redacted] and then coughed up copious amounts of [redacted] and food. The Advanced Practice Registered Nurse was called and instructed the nurse to call emergency medical services ([redacted]). At approximately 5:30 PM, [redacted] arrived, the resident was suctioned, and [redacted] was applied. At approximately 5:40 PM, he was transported to the local hospital.<br><br>In her written statement, the RCS indicated she served resident #2 the French Dip Roast Beef Sandwich, and she was aware the resident was on a mechanical soft diet. The resident requested the sandwich and because it was French Dip, she thought the sandwich was considered mechanical soft. Shortly after he began to eat the sandwich, she noticed that he was coughing more than normal. She called nurse to access him.<br><br>The LPN indicated in her statement that the resident coughed more than usual but was able to breath. He was trying to [redacted] something up unsuccessfully on his own but seemed to clear it. He then began coughing again and he then brought up copious amounts of [redacted] and some food. His [redacted] sounds were diminished but his [redacted] saturation was at 94%. He returned to the facility at approximately 10:30 PM and slept well. At 6:30 AM, he started to [redacted] again. [redacted] was called again, he was transported [redacted] to the local hospital, and was admitted. She said the | A 025 | | |

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| A 025 | Continued From page 4 | A 025 | | |

resident's daughter stated that he had a swallow evaluation completed and passed. He was given a regular diet meal and he choked on his meal. He went to a skilled nursing facility for rehabilitation.

Health assessment report dated . . . . . included , , and with hospice services. Special precautions included . , . . . . A mechanical soft/nectar thickened liquid diet was ordered. The order dated . . . . . was for nectar thick liquid mechanical soft diet per ST recommendation.

Facility notes indicated the following:
- "New order for , . . evaluation due to increased chocking/coughing during meals."
. . . . . at 7:43 PM - "At approximately 5:15 (PM) was coughing. Not unusual for resident to . . . but . . . continued. The writer thought he was chocking but was able to breathe. He had chosen a roast beef sandwich. Writer removed plate. continued, threw up and food. . . . subsided for a moment but started again. ( ) saturation was 94%, Advance Practice Registered Nurse was called, emergency services called, taken to emergency room."
at 1:26 AM - "Returned to facility with diagnosis of , , . / . , . . . . . New prescription for 300 mg. (milligrams) one tablet every 6 hours for 10 days and . . 500 mg. one every 12 hours for 7 days."
. . . . . at 5:15 PM - "went . . . to hospital for persistent and copious amount of . . . . . 77%."
at 12:10 PM - "He was admitted for . . . . . Undergoing speech evaluation."

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| A 025 | Continued From page 5<br><br>. . . . . - "Returned to facility at 11:20 AM orders for on mechanical soft diet with regular liquids."<br><br>On . . . . . , the administrator said that regarding resident #2, the staff was aware the resident needed a mechanical soft diet and she thought the French Dip Roast Beef Sandwich was mechanical since it was dipped.<br><br>Class II | A 025 | | |