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 |
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| | AL11968003 | A. BUILDING: _____ B. WING _____ | 06/01/2022 |

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| GRAND VILLA OF MELBOURNE | 964 S HARBOUR CITY BLVD MELBOURNE, FL 32901 |

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| A 000 | Initial Comments<br><br>Complaint Investigation #2022002932 was conducted on [redacted]. Grand Villa of Melbourne had a deficiency at the time of the survey. | 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 [redacted] or [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted] or [redacted]. 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 [redacted] 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 Resident Care Standards.<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 | | |

AHCA Form 3020-0001

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

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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 record reviews and interviews, the facility failed to provide adequate supervision and care and services appropriate to meet the needs to ensure safety through proactive measures to minimize the potential for [redacted] and injuries for 3 of 4 sampled residents who experienced repeated [redacted] with injuries (#1, #3 & #4).<br><br>Findings:<br><br>1. Resident #1's record revealed a facility admission date of [redacted]. An 1823 health assessment form, dated [redacted], indicated the resident's diagnoses were [redacted], and Non-[redacted], and | A 025 | | |

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| A 025 | Continued From page 2<br>. The form also indicated the resident required assistance with activities of daily living (ADLs), ambulation, and transferring.<br><br>Review of the resident's record revealed the following documentation:<br><br>On , the resident moved from the assisted living part of the facility to the secured memory care unit.<br><br>On at 5:40 p.m., the resident was found sitting on the floor in the hallway. The resident did not have any complaints and no visible injuries. Physical ( ) and Occupational therapies ( ) were ordered.<br><br>On at 10:45 a.m., the resident complained of and stumbled while ambulating.<br><br>On at 2:30 p.m., the resident was observed on the floor in the memory care TV room. He was unable to say what happened. He sustained a on his right . He was assisted off the floor, was extremely unsteady, and had to be sitted in a wheelchair. He was nonverbal. A post investigation indicated he had on ill-fitting shoes, his gait was unbalanced, and he did not use a walker. The post intervention was that staff would walk him to and from the dining room for meals and would engage him in activities. A hospice consultation was ordered.<br><br>On at 1:30 p.m., the resident's gait was unsteady. He was admitted to hospice services.<br><br>On at 12:15 p.m., the resident's gait was slow and unsteady. He was escorted to meals. | A 025 | | |

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| A 025 | Continued From page 3<br><br>He wore socks and was encouraged by staff to wear shoes.<br><br>On at 1:45 p.m., the resident went outside via the doors when a staff member saw and followed him. The staff member reached to hold the resident's . The resident was unable to stand, and to the ground. He did not sustain any injuries. A post- investigation indicated the resident wore slippers at the time of the . Facility interventions would include monitoring the resident for safety and well-being, assist him during transfers, and encourage him to use his call button.<br><br>On at 2:45 p.m., the resident was in his room walking around and holding onto things. He was escorted to the dining room then and his gait was unsteady. He almost when he sat on his bed. He was unable to judge the correct distance and unable to determine safety.<br><br>On at 2:15 p.m., the resident's gait was unsteady. He ambulated without assistance and when reminded, he complied. He would sit in a wheelchair but, often stood up from it.<br><br>On at 2 p.m., the resident put on and removed his shoes often and his gait was unsteady.<br><br>On at 5:45 p.m., the resident was found lying on a hallway floor. He wore only one shoe and could not remember how he . He did not sustain an injury.<br><br>On at 1:30 p.m., the resident's gait was slow and unsteady.<br><br>On at 11:45 a.m., the resident was | A 025 | | |

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| A 025 | Continued From page 4<br><br>found lying on the TV room floor next to his wheelchair. He did not sustain an injury. A post- investigation indicated the resident oftentimes walked alone and without his wheelchair. He did not have safety awareness and was very . Staff monitored him for proper footwear, but he would either not wear shoes or would wear slippers.<br><br>On at 6:15 p.m., the resident's condition at the time of the on that morning was and . He would not remain in his wheelchair and had to be monitored one on one.<br><br>On at 6:15 p.m., the resident remained and and made frequent attempts to get out of his wheelchair and walk alone. His gait was unsteady.<br><br>On at 10:15 a.m., the resident was seen lying on a hallway floor near an exit door. He did not sustain any visual injury. His gait remained unsteady, and he refused to sit in a wheelchair. His shoes were untied and oftentimes changed them.<br><br>On at 2 p.m., the resident had a large on the left side of his . His gait remained unsteady, and he ambulated without assistance. Staff continued to monitor his shoes for safety and redirect him to the wheelchair.<br><br>On at 9:50 a.m., a employee saw the resident's give out and the resident to the floor.<br><br>On at 10:30 a.m., the resident was seen on a hallway floor. He did not sustain an injury. | A 025 | | |

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| A 025 | Continued From page 5<br><br>On ... at 10:45 a.m., the resident was seen on the floor near the activity door and in front of the nurses' station. He was assisted up and placed in a wheelchair but, he continued to get up from the wheelchair.<br><br>On ... at 3:15 p.m., the resident was seen by staff trying to sit down in a chair when he missed the chair and sat on the floor. No injuries were sustained.<br><br>On at 10:15 a.m., the resident's gait remained unsteady however, he refused to use a walker or wheelchair. Staff reminded and encouraged him to do so.<br><br>On at 4:30 p.m., the resident was seen on a hallway floor. He wore only one shoe. Footage from a facility camera revealed the resident sat down on the floor then laid on his ... .<br><br>On ... at 1:15 p.m., the resident was seen lying on the floor. Camera footage revealed the resident eased himself to the floor then laid down.<br><br>On at 3:55 p.m., the resident was found sitting on a hallway floor with his against the wall. No injuries were sustained.<br><br>On ... at 4 p.m., the resident was found sitting on a hallway floor. No injuries were sustained.<br><br>On ... at 6:45 p.m., the resident was seen lying near his wheelchair on the floor in the common area. Camera footage revealed the resident tried to transfer himself from the wheelchair to a recliner chair and to the floor. No injuries were sustained. | A 025 | | |

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| A 025 | Continued From page 6<br><br>On at 2:15 p.m., a 45-day facility discharge notice was issued to the resident due to repeated .<br><br>On at 9:45 a.m., staff reported that the resident was found on the floor between his side of the room and his roommate's on . No injuries were sustained. The staff would monitor him more frequently while he was in his room.<br><br>On at 11 a.m., the resident was found on the floor in front of his bed. No injuries were sustained. He was difficult to get off the floor and was unable to ambulate.<br><br>On at 4:30 p.m., the resident complained of right , and was seen. He was able to bear but hopped around. An was ordered.<br><br>On at 12:15 p.m., the resident complained of increased in his right and medication was ordered.<br><br>On at 2:15 p.m., the resident was heard calling for help from his room. He was seen lying on the floor at the of his bed and wearing only one shoe.<br><br>A facility note, dated at 10:45 a.m., indicated the writer of the note was informed on at 3:30 p.m. that the resident had a on at 11:30 p.m. The resident complained of in his right and was seen. He screamed out in when care was provided. of his right were negative for .<br><br>On at 1:45 p.m., the resident was in bed | A 025 | | |

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| A 025 | Continued From page 7<br>due to his inability to ambulate.<br><br>On at 6:15 a.m., the resident was found on the floor.<br><br>On at 1:15 p.m., hospice provided floor mats. The resident was checked on frequently.<br><br>On at 8:30 a.m., the resident was seen with his hanging out of the bed. His right , was larger than the left one and his were . He screamed in .<br><br>On at 2:15 p.m., an , revealed the resident had a right . He was transported to the hospital.<br><br>On , the resident was discharged from the facility due to moving to a skilled nursing facility.<br><br>During an interview with caregiver C on at 2:53 p.m., she said she always tried to keep resident #1 in the common areas so he could be watched more closely.<br><br>During an interview with caregiver D on at 2:55 p.m., she said she always kept the resident in a wheelchair and made sure the footrests were on it and kept him in her sight.<br><br>During an interview with caregiver E on at 2:57 p.m., she said that at times, she positioned the resident's wheelchair outside of each room she went into, so he was nearby. She said she also gave him activities to do.<br><br>During an interview with caregiver A on at 3:32 p.m., she said there wasn't much they could do to prevent the resident from falling. She said the staff tied his shoes often, put his shoes | A 025 | | |

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| A 025 | Continued From page 8<br><br>on, and tried to keep him within eyesight however, it was difficult to keep him still. She said that when the resident was in his room, staff checked on him every hour. She said the resident moved frequently throughout the night and oftentimes, he was found sitting on the side of his bed.<br><br>During an interview with the memory care manager on at 4:04 p.m., she said the resident would never sit down. She said he was placed with activities and at the nurses' station to be closely watched. She said staff kept him out of his room, offered him snacks, obtained better shoes for him, floor mats, high-low bed, and a better wheelchair.<br><br>2. Resident #3's record revealed a facility admission date of . An 1823 Health Assessment Form, dated , indicated the resident's diagnosis were , II, and . The resident was assessed to be alert with mild and ambulates with a walker. The resident required assistance with bathing and supervision with and . The 1823 documented special precautionsn - risk. Photographic evidence was obtained.<br><br>Review of nurses' notes documented on the following dates:<br><br>at 5:15 PM, resident was found lying on the floor of his room on his right side. The resident had no apparent injuries.<br><br>at 7:30 AM, the resident out of bed. The resident was transferred to the hospital due | A 025 | | |

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| A 025 | Continued From page 9<br><br>to complaints of . He returned at 7:15 PM with diagnosis of concussion and to the right and right upper quadrant.<br><br>at 6:45 AM, the resident in his room. He was lying on the floor next to his recliner. was noted on his /. The Director of Nursing (DON) advised the medication technician (med tech) to call Emergency Medical Services ( ). The resident was transported to the hospital. He returned to the facility at 11:45 AM with to the , right and .<br><br>at 5:15 AM, the resident was found on floor by the of his bed. He complained of left . The DON was called and advised the med tech to call . The resident was transported to the hospital where he was diagnosed with a left . The resident was discharged from the hospital to rehabilitation facility.<br><br>The resdident returned to Grand Villa of Melbourne on .<br><br>at 9:30 AM, the resident was found kneeling on the floor with his upper body on bed and his on the floor. Per nurse's note of , the resident was transferred to a rehabilitation facility. Photo evidence was obtained.<br><br>2:50 PM, staff G stated the resident would ambulate in his room with his walker. He did walk without assistance. He had a walker and a wheelchair usually next to his bed. He did not use the call bell because he was forgetful. Sometimes resident #3 needed to be prompted and cued to get in bed properly so he was | A 025 | | |

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| A 025 | Continued From page 10<br>straight. Staff G stated she would remind him to use the walker and wear socks.<br><br>3:10pm staff B stated, she would check on him about 5 times a day. Resident #3 did not leave his room. She checked on him when delivering meals or providing care or showers.<br><br>4:36 PM, the DON stated resident #3 had a wall call light and he was reminded to use it. The DON stated she spoke to resident #3 about but he would just get up and then . The DON stated resident #3 stayed in his room most of the time.<br><br>3. Resident #4's record revealed a facility admission date of . An 1823 Health Assessment Form, dated , indicated the resident's diagnosis were , history of replacement, surgery, and an unsteady gait. The 1823 also indicated the resident needed supervision with bathing, , grooming, and transferring. The resident was independent for ambulation and eating, or behavioral status was stable, she was tearful at times, and . Photo evidence was obtained.<br><br>Review of Nurses Notes documented on the following dates:<br><br>at 8:30 AM, staff reported last night the resident was found on her on the floor in the hallway. The resident had no apparent injuries.<br><br>at 4:30 AM, the resident was found on | A 025 | | |

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| A 025 | Continued From page 11<br><br>the floor in her room by a hospice nurse. The nurse was there to evaluate resident's complaint of . . . . . . The resident was in a . . position. The resident had no apparent injuries.<br><br>at 10:52 PM, the resident was found sitting on the floor in her apartment. She alerted staff by banging on the door. The resident had no apparent injuries.<br><br>. . . . . at 6:42 PM, the Memory Care Director documented she was notified via telephone of the resident falling after being kicked by another resident. The resident had no apparent injuries.<br><br>at 6:42 AM, the resident lost her balance and . . after being escorted by staff out of her room. No injury was documented.<br><br>at 11:45 AM, the resident was observed sliding out of the wheelchair onto the floor. The resident had no apparent injuries. The Memory Care Manager documented, "Does not understand safety."<br><br>at 12:15 PM, the resident pushed herself backwards from table in hallway by dining room causing her wheelchair to backwards. The resident had no apparent injuries.<br><br>. . . at 12:15 PM, the resident was observed on the floor in front of the wheelchair. The resident had no apparent injuries<br><br>. . . . . at 3:45 PM, the resident was found on the floor in the hallway in front of . The Memory Care Manager documented in nurse's note, "Often gets out of her wheelchair and ambulate unsafely." The resident had no apparent injuries. | A 025 | | |

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| A 025 | Continued From page 12<br><br>at 5:40 PM, the resident was found lying on the ground outside sleeping. Staff was alerted of situation by another resident. The resident had a . to the left arm.<br><br>at 3 PM, the resident was found lying on the floor in her room. The resident had no apparent injuries.<br><br>2:30 PM The RCM was pushing the resident to breakfast, the resident forward from her wheelchair because she put her down while being pushed to breakfast by staff. the resident had no apparent injuries.<br><br>at 10 AM, the resident was found on the floor in the common living room. The resident had no apparent injuries and was assisted to her wheelchair.<br><br>at 1:45 PM, the resident was found lying on the floor in the hallway in front of her wheelchair. No apparent injuries were seen.<br><br>at 1:45 PM, the resident was lying on the floor in the TV room. She was returned to her wheelchair after another resident alerted staff of the . The resident had a . to the right .<br><br>at 7:45 AM, the resident was found lying on her left side on the floor in the TV room. was noted from her left temple and left transported the resident to the hospital where she was diagnosed with a . Photo evidence was obtained.<br><br>at 3:50 PM, staff A stated resident #4 | A 025 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11968003 | A. BUILDING: _____ B. WING _____ | 06/01/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GRAND VILLA OF MELBOURNE | 964 S HARBOUR CITY BLVD MELBOURNE, FL 32901 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| A 025 | Continued From page 13<br>would . . . around the unit, and she was hard to keep up with. She would slide from the wheelchair for no reason. Staff A stated they would keep her within , site, and they would involve her in activities.<br><br>. . . at 4:12 PM, the Memory Care Director (MCD) stated resident #4 all over and walked around all the time. She also stated resident #4 ended up in a wheelchair but she would get up and walk. In an attempt to decrease , the MCD stated she would take resident #4 to activities, do a lot of one-on-one activities with her, give her puzzles and snacks. They tried to keep her out of her room so staff could see her. The MCD stated there is enough staff according to the facility.<br><br>Class II | A 025 | | |