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
	AL11968003	A. BUILDING: _____ B. WING _____	R 12/20/2023

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

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CZ821	59A-35.110( ) FAC Reporting Requirements; Electronic Submission 59A-35.110 Reporting Requirements; Electronic Submission. (1) During the two year licensure period, any change or expiration of any information that is required to be reported under Chapter 408, Part II, F.S., or authorizing statutes for the provider type as specified in Section 408.803(3), F.S., during the license application process must be reported to the Agency within 21 days of occurrence of the change, including: (a) Insurance coverage renewal; (b) Bond renewal; (c) Change of administrator or the similarly titled person who is responsible for the day-to-day operation of the provider; (d) Annual sanitation inspections; (e) Fire inspections. (2) Electronic submission of information. (a) The following required information must be submitted electronically through the Agency's Single Sign On Portal located at https://apps.ahca.myflorida.com/SingleSignOnPortal: 1. Nursing homes: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 400.147, F.S. on Nursing Home Adverse Incident, AHCA Form 3110-0010 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08777, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal.	CZ821		

AHCA Form 3020-0001

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

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CZ821	Continued From page 1 2. Assisted living facilities: Adverse incident reports must be submitted electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident as required in Section 429.23, F.S., on Assisted Living Facility Adverse Incident, AHCA Form 3180-1025 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08778, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 3. Hospitals: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Hospital Adverse Incident, AHCA Form 3140-5001 OL, , , which is hereby incorporated by reference and available at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08779, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 4. Ambulatory Surgical Centers: Adverse incident reports must be submitted electronically to the Agency within 15 calendar days after the occurrence of the incident as required in Section 395.0197, F.S., on Ambulatory Surgical Center Adverse Incident, AHCA Form 3140-5004 OL, , , which is hereby incorporated by reference and available	CZ821		

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CZ821	Continued From page 2 at: https://www.flrules.org/Gateway/reference.asp?No=Ref-08780, and through the Agency's adverse incident reporting system which can only be accessed through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 5. Hospitals and ambulatory surgical centers must submit annual reports pursuant to Section 395.0197 F.S., electronically to the Agency on Annual Report, AHCA Form 3140-5005 OL, , , which is hereby incorporated by reference and available at: http://www.flrules.org/Gateway/reference.asp?No=Ref-12123, and through the Agency's Single Sign On Portal located at: https://apps.ahca.myflorida.com/SingleSignOnPortal. 6. For the purposes of this rule, the following applies for submitting adverse incident reports: a. A business day means any day other than a Saturday, Sunday, or legal holiday as designated in Section 110.117, F.S. b. A preliminary (1-Day) report is deemed late when submitted more than 1 business day after the day of the incident. c. Nursing Homes, Hospitals, and Ambulatory Surgical Centers: A full report (15- Day) is deemed late when submitted more than 15 calendar days after the day of the incident. d. Assisted Living Facilities: A full report (15-Day) is deemed late when submitted more than 15 calendar days after the day of the incident or more than 3 business days after the Agency issues the reminder pursuant to Section 429.23(5), F.S., whichever is later. e. Assisted Living Facilities and Nursing Homes that submit reports deemed late may be fined up	CZ821		

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CZ821	Continued From page 3 to $50 per day late not to exceed $500. (b) The licensee must retain a copy of all documentation generated at time of reporting as confirmation of successful electronic submission. (c) If the Agency's Single Sign On Portal or the online adverse incident reporting system is temporarily out of service the licensee may contact the Agency directly at 1(888)419-3456 for assistance. Reporting will resume as soon as online access is restored. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to submit an Adverse Incident electronically to the Agency within 1 business day after the occurrence of the incident, and within 15 calendar days after the occurrence of the incident for 2 of 4 residents sampled. (resident #3 and 4) Findings: On . . . . . resident #3 was observed in the hallway lying down on top of her walker. A . . injury was noted. She was transferred to the hospital where she was found to have . . . . . hematoma. She was kept overnight for observation. On at 7:09am resident #4 was found on the floor in his apartment. He complained of right , and was transferred to the hospital. He was admitted to the orthopedic floor. On . . . . . at 5:17pm in an interview with the administrator, he confirmed residents #3 and #4 were transferred to the hospital for evaluation after sustaining . He also confirmed there were no adverse incident reports submitted to the agency for resident #3 or #4.	CZ821		

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CZ821	Continued From page 4 Unclassified	CZ821		
{A 000}	Initial Comments A revisit complaint #2023010146 was conducted on at Harborside at Melbourne Assisted Living Facility. The deficiency remained uncorrected at the time of the visit.	{A 000}		
{A 025} SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (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. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility.	{A 025}		

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{A 025}	Continued From page 5 (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (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. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (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. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (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. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide care and services appropriate to meet the needs of residents by failing to provide adequate supervision for 1 of 4 sampled residents. Resident (#3) who sustained multiple with injury. Findings:	{A 025}		

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{A 025}	Continued From page 6 On [redacted] at 12:10pm Resident #3 was observed in the dining room. She had dark purple [redacted] around her [redacted] and her right [redacted] was [redacted] and [redacted]. She was unable to verbalize what happened or when. A review of resident #3 record revealed she was admitted [redacted] to the memory care unit. Her record contained a Resident Health Assessment form (1823) dated [redacted], Her original 1823 dated [redacted] had "[redacted]" documented under special precautions. She required assistance with ambulation, transfer, bathing, [redacted], and toileting. Her diagnoses included [redacted], and [redacted] hematoma. She used a walker for ambulation. A review of the facility notes revealed resident #3 had 6 [redacted] since her admission to the memory care unit. 3 [redacted] resulted in injury requiring transfer to the hospital where she received a higher level of care. On [redacted], the day resident was admitted, documented at 3:12pm resident stood up, pushed her walker away, and [redacted] down on her [redacted] in the activity room. No injuries. On [redacted] documented at 3:26pm, resident [redacted] next to the medication cart and hit her [redacted] on the wall. She was transferred to the hospital with a [redacted] to the left side of her forehead. She received 13 [redacted] to her forehead at the hospital and returned to the facility. On [redacted] at 1:37pm, resident was on the floor sitting in the bathroom doorway of another resident's room. Her walker was a few [redacted] away. She was [redacted] from her [redacted]. Transferred to the hospital for evaluation and treatment. On [redacted] She returned to the facility at 8pm.	{A 025}		

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{A 025}	Continued From page 7 On documented at 7:03am resident was observed trying to sit on her regular walker and she on her before staff could get to her. On documented at 1:29pm. Resident observed on the floor sitting on her bottom. No injuries noted. On documented at 12:22pm - resident observed in the hallway lying down on top of walker. injury noted. Transferred via 911 to the hospital. On documented at 1:47pm resident's daughter called and stated resident had a small hematoma and she was staying overnight at the hospital. On documented at 4:24pm. The resident returned to the facility from the hospital. to . Resident #3's record review did not find documentation of resident specific mitigating strategies to decrease her risk of and injury. On at 2:45pm in an interview with Staff F. She said not all residents have call pendants to push for assistance. There is a fee for that pendant. There are pull in the bathrooms and the bedroom in each apartment which can be used to call for assistance. Not all residents in the memory Care Unit possess the capacity to use the call system. A review of the facility policy dated revealed the purpose of the policy and procedure was to provide an overview of the process of a resident being observed on the floor. The policy did not refer to strategies to decrease the likelihood of and injury. On at 5:17pm in an interview with the	{A 025}		

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{A 025}	Continued From page 8 administrator he confirmed the above findings. Class II	{A 025}		