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 _____	02/12/2024

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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A 000	Initial Comments A survey for complaint #024000351 2024000127 2023018564 was conducted on [redacted] at Harborside at Melbourne Assisted Living Facility. A Limited Nursing Service (LNS) initial survey and capacity increase was attempted and was unable to be conducted due to the administrator not being aware or prepared. There were deficiencies identified at the time of the survey.	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 [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]. 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. 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. (1) SUPERVISION. Facilities must offer personal	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 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 to prevent an injury of unknown origin and . . . with injuries for 3 of 7 sampled residents (#1, #6 and #7) Findings: A review of the facility progress notes for resident	A 025		

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A	Continued From page 2 #1 revealed on ..... the resident was sent to the hospital based on the family request because resident complained of , and . . , . when the family was visiting. She was diagnosed with a right , ... which occurred within 24 hours before going to the hospital. She returned to the facility on . . . . . . A review of resident #1 record revealed she was admitted on and lived in the secure memory care unit. Her record contained a Resident Health Assessment form (1823) dated . . . . . Her diagnoses included and spasms. She required assistance with transfer and ambulation. She was alert with . Further review of her record revealed an 1823 dated . risk was documented under special precautions. Review of her individualized Service Plan revealed it had not been updated with appropriate mobility interventions since her readmission on . . . . . . On ... . at 10:15am resident #1 was observed in a wheelchair in the activity room in the memory care unit. There were no staff present in the activity room. A music video was playing on the television. Nine residents were seated in the room. A review of resident #6's record revealed he was admitted on . He lived in the secure memory care unit. His file contained an 1823 dated which identified him as a . risk. His diagnoses included , repeated , and . He required supervision transfer and assistance with ambulation.	A 025		

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A 025	Continued From page 3 A review of the facility progress notes found the following: ; On at 10:28am resident sitting on the floor. Not in wheelchair. On resident and hit his Transferred to the hospital. On transferred to the hospital due to in bedroom. Trying to stand up from wheelchair. "Resident is not able to be educated and is not aware of limitations. Staff to reinforce resident to stay in wheelchair at all times." On resident was sitting on the floor in the TV room. On at 5:39pm resident kneeling on the ground. Wheelchair unlocked. A review of resident #7's record revealed she was admitted on . She lived in the secure memory care unit. Her record contained an 1823 dated . Her diagnoses included , hematoma, and . She required assistance with all activities of daily living except she required supervision for eating. A review of the facility notes revealed: On at 3:16pm resident found down on the floor with walker under her. from and transferred to the hospital. On documented at 10:36pm resident in common living room. Hit her on a walker. Then observed (camera footage) being assisted up off the floor and to recliner by 2 other residents. On at 8:50am in bedroom	A 025		

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A 025	Continued From page 4 On ... . at 11:03am . in living room (common area). Was using walker and wearing house slippers. On at 10:44am found leaning against the wall in her bedroom. Stated she did not know how she . On .. .. at 3:42pm resident found on the floor in common area living room. Found sitting on her bottom. On .. .. at 3:45pm an interview was conducted with the Director of Nursing (DON). The DON was asked about the availability of camera footage showing resident #7 in the common TV area of the Memory Care (MC)C unit. On at 4:20pm a review of the video footage from .... revealed: At 1:20pm resident #7 was seen getting up from a recliner with her walker in the memory care unit common TV area. 2 other residents were present. No staff were seen in the common TV room. At 1:23pm resident #7 returned to the TV room walking with walker. No staff were seen in the common TV room. At 1:34pm resident #7 left the TV room again. No staff were seen in the common TV room. At 1:36pm A staff member enters at the same time as resident #7 and they leave the common TV area together. At 1:46pm resident #7 returned to the TV room. No staff were seen in the common TV room. At 1:48pm resident #7 left the common TV area. At 1:54pm resident #7 entered and while turning to sit in a recliner. No staff were seen in the common TV room. At 1:55pm resident #9 who had been seated in a recliner in the TV room, went and got a male	A 025		

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A 025	Continued From page 5 resident. Together they helped resident #7 . . . into the recliner. No staff were seen in the common TV room. At 1:58pm resident #9 left the TV room. On at 4:40pm in an interview with Staff G. She said resident #9 came to the desk in MC and asked if someone would come because they needed help. She went to look, and no one was on the floor. Everyone looked okay. No complaints. Later, when the staff was showering resident #7, they found dry in her hair and reported it. They checked the video camera footage to see what happened. On at 4:50pm in an interview with the DON, she said she watched the footage to determine how resident #7 was injured because no staff witnessed or assisted her off the floor. The footage revealed two memory care residents assisted resident #7 off the floor and . . . into a recliner. She confirmed there were no staff present in the TV common area at the time of resident #7 on . She said the staff were changing other residents. There were four care staff scheduled. On At 5pm in an interview with administrator, he said they can't stop the impulsive residents from falling. A review of the facility policy titled Mobility and . . Management dated . . . . revealed the facility would have appropriate interventions identified and documented in the resident's progress notes. Class II .	A 025		

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A 052 SS=D	429.256( ); 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the	A 052		

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A 052	Continued From page 7 prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , , converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a of the body. (d) Administration of preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with , , or preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008	A 052		

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A 052	Continued From page 8 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be , , , or older, trained to assist with self administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the	A 052		

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A 052	Continued From page 9 resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's . . . . . control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview the facility failed to follow proper procedures when assisting with self-administration of medication for 1 of 2 residents sampled (#5). Findings: On . . . . at 10:20am observation of staff B assisting resident #5 with self-administration of medication. Staff B was observed standing at the medication cart preparing medication for resident #5 who was seated at the opposite end of the hallway. Staff B placed one crushed tablet in a	A 052		

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A 052	Continued From page 10 small cup with pudding. She locked her cart and carried the small cup down the hall to resident #5. Staff then spooned the pudding/medication mixture into the resident's . At 10:25am Staff B confirmed she was not qualified to administer medications. She said resident #5 would not put the medicine in her . On /at 10:35am the Director of Nursing confirmed staff B used improper procedure when assisting resident #5 with self-administration of medication. Class III	A 052		