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
	AL11969035	A. BUILDING: _____ B. WING _____	09/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA SENIOR LIVING OF PALM BAY	3490 GRAN AVE PALM BAY, FL 32905

(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 000	Initial Comments AMENDED A0025 Class II A survey for complaint number 2024010716 was conducted on , and at Grand Villa Senior Living of Palm Bay. The facility had deficient practices 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 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. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following:	A 025		

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A 025	Continued From page 1 (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, 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 and injuries for 5 of 7 sampled residents who experienced with injuries (1, 3, 5, 6, 7). Findings: 1. On at 9:45am resident #1 was assessed by her primary care provider (PCP) and was transferred to the hospital for right ankle	A 025		

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A 025	Continued From page 2 ب and ب. At the hospital she was diagnosed with a right ankle . Review of resident #1 record revealed she was admitted to the facility on . She transferred to the Memory Care Unit on . Her record contained a Resident Health Assessment form (1823) dated . Her diagnoses were oriented with forgetfulness, ، ، ، ، and . She required assistance with ambulation, bathing, and ب. She used a wheelchair for ambulation. A review of the facility notes found: On Nurse A wrote a late entry note - on at approximately 11:00am resident #1 complained of , to her right ankle and her lower . nurse A observed her right ankle to be slightly edematous, but no discoloration noted. Unlicensed caregiver J notified the Primary Care Provider (PCP), via text about resident #1's , and discomfort. The PCP asked unlicensed caregiver J if the resident had taken her morning , medication, which she replied yes. Nurse A also documented in the same late entry that on nurse B notified her about resident #1's ankle being discolored. Nurse A documented she advised nurse B to call the PCP for X-ray orders. There was no documentation of the PCP being notified of resident #1's condition. Nurse A continued to write in the same late entry note that on resident #1 was evaluated by the PCP and ordered to go to the hospital for of the right ankle. The resident was transferred to the hospital by non-emergency transport. Nurse A documented at 6:37pm the Memory Care Director (MCD) told her resident #1 had two to her right ankle. On at 5:37pm an interview was conducted	A 025		

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A 025	Continued From page 3 with Nurse A. She said she did a late entry because she did not remember to chart. On at 12:29pm Nurse B stated in an interview she called the PCP on Sunday at approximately 10:45am. She said the PCP does not have an answering service, but the PCP's office does encourage you to leave a message, and someone will get in touch with you. Nurse B stated she did not get a call from the PCP and did not make a follow up call to the PCP nor did she make nurse A aware of the PCP not returning her call. Nurse B stated that she just assumed nurse A would have called the PCP to do a follow up call on Monday when she was scheduled to work. On at 1:09pm Nurse A stated in an interview, Nurse B did not make her aware of the PCP not returning her call regarding resident #1 on . Nurse A stated that she would have reached out to the PCP with a follow-up call. On at 12:43pm unlicensed caregiver C stated that she worked on into , third shift (11pm- 7am). Unlicensed caregiver C stated at about 2:30 am on while conducting her rounds there was someone screaming for help. When she got to resident #1's room she found the resident sitting on the floor with her against the bed saying she must have rolled out of bed. Unlicensed caregiver C stated she radioed for help and unlicensed caregiver D came to assist her in putting resident #1 to bed. This writer asked what the facilities protocol was when a resident . unlicensed caregiver C stated it was protocol for the staff to fill out an incident report with what happened to the resident. Unlicensed caregiver C stated there were no incident reports on the unit	A 025		

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A 025	Continued From page 4 at the time, nor did she call another unit to get a form to fill out. Unlicensed caregiver C stated at the end of her shift she went home and forgot about the entire incident. On at 5:05pm unlicensed caregiver D stated around 2:30am on unlicensed caregiver C called over the radio saying she needed help on the fourth floor. Unlicensed caregiver D stated she was a lead tech for the facility. She stated she was the one that went between the units to assist all the other caregivers in the building. There were only three people running the memory care units at night. When she got to resident #1's room, the resident was on the floor saying she rolled out of bed. Unlicensed caregiver D stated she asked resident #1 if she wanted to go to the hospital for evaluation and she said no, she wanted to be put to bed. She stated that her and unlicensed caregiver C placed resident #1 into her bed. She said unlicensed caregiver C was supposed to have done the incident report. She stated herself and unlicensed caregiver C should have let someone know about the incident immediately. She confirmed she did not notify her supervisor. On at 2:25pm unlicensed caregiver F stated on resident #1 was due to get a shower but the resident refused saying that she was in a lot of , . Unlicensed caregiver F stated she notified nurse B stating the resident had a huge with a lot of discoloration and it was . Nurse B told her that she was going to call the PCP and get a portable X-ray done of her right . Unlicensed caregiver F stated nurse B asked the resident to take a bed bath which she agreed to. Unlicensed caregiver F stated she did go ahead and give resident #1 a bed bath but the	A 025		

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A 025	Continued From page 5 resident was in quite a bit of . She was moaning and at times crying. She stated resident #1 was really in a lot of . A review of a note documented by a , assistant (PTA) for the date of service . She documented: The session was shortened today due to resident #1 request due to fatigue and in right ankle. Nursing staff aware. Unable to stand for more than 3 seconds. She was instructed on shifting in seated position to help alleviate . Resident and Caregiver training, verbalized understanding of techniques performed today. The review of this document did not find any staff names. PTA did not respond to interview requests. On at 6:15pm an interview with the Assistant Executive Director ( ) was conducted. She confirmed the findings. 2. On at 9:41pm resident #3 was found by unlicensed care staff (E) lying on the floor in her room next to her wheelchair. She was transferred to the hospital. She was admitted with a large to her left lower extremity with (tearing away of body part or structure) and exposed requiring 10 stitches. A review of resident #3 record revealed she was admitted on and she lived in the memory care unit. Her record contained an 1823 dated . Her diagnoses included , , disturbances, and	A 025		

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A 025	Continued From page 6 . She was under hospice care. A review of the facility notes found: On a documented by nurse (B) at 5:15am. The writer was notified this am that last evening staff reports at 9:40pm they found resident on the floor. She was transferred to the hospital On at 4:50pm resident returned to community. A review of an internal incident report dated signed as completed by nurse (A). She documented resident #3 said she was trying to , the kitty but remembered she had no kitty. The resident uses a walker but was not using it at the time of the (unwitnessed) . There were no interviews conducted with the staff who found her. No resident specific interventions were documented to mitigate with injury except to remind the resident with a diagnosis of , to ask for assistance. On at 6pm an interview with the Assistant Executive Director ( ) was conducted. She confirmed the findings. 3. On at 7:09am resident #5 was found in his apartment pale and diaphoretic sitting in his recliner by nurse (A). The resident was unable to say what happened. He was transferred to the Hospital where he was admitted with a left , . A review of resident #5 record revealed he was admitted on and discharged . He lived in the memory care unit. His record contained an 1823 dated . His diagnoses included , behavioral disturbances, , , disturbances, disturbances, , , , and , . He required	A 025		

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A 025	Continued From page 7 assistance with bathing, , grooming, toileting, and transferring. Review of the facility notes found: On documented by nurse (F) at 12:30pm. The resident observed laying on the floor by hallway door in his room. He was transferred to the hospital for and increased . On documented by nurse (A) Resident observed trying to sit on the seat of walker. He slid to the floor. He was assisted up and independently ambulated with a steady gait with walker. On documented by nurse (A) at 7:10am called to check on resident who was observed slumped to the left in recliner. Transferred to the hospital via 911. On at 6pm an interview with the Assistant Executive Director ( ) was conducted. She confirmed the findings. 4. On at 3:15pm unlicensed care unlicensed caregiver (H) heard resident #6 yelling for help. The resident was found sitting on her walker outside her room. Resident #6 stated she in her room and broke her . She was checked by nurse (B) and transferred to the hospital where she was diagnosed with a left . A review of resident #6 record revealed she was admitted on and she lived in the memory care unit. Her record contained an 1823 dated . Her diagnoses included , , , and , . She used a walker. She was a risk. She was under	A 025		

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A 025	Continued From page 8 hospice care. She required assistance with ambulation, grooming, and toileting. A review of the facility notes found: On documented by nurse (B) at 6pm. The writer was called to the fourth floor by an unlicensed caregiver (H) who stated the resident had an unwitnessed and is complaining of left , . Upon observation the appears . Transferred to the hospital. On documented by the Memory Care Director (MCD) at 4pm. At approx. 3:15pm on . Resident Yelling. Unlicensed care staff (H) observed the resident sitting on her walker outside her room. She stated she and broke her . Transferred to the hospital and diagnosed with a left . A review of an internal incident report dated signed as completed by nurse (A). There were no interviews conducted with the staff who were working in memory care at the time of the incident. No resident specific interventions were documented to mitigate with injury. On at 5:40pm Nurse A confirmed the findings. 5. On at 10pm resident #7 in the common area of the Memory Care unit. Unlicensed care staff (H) asked the resident if she hit her , and she replied yes and she was holding the of her . Resident was transferred to the Hospital. On at 1:05pm resident #7 when attempting to stand from the dining room chair in the memory care unit. She complained of right , and , . She was transferred to the hospital and diagnosed with a right	A 025		

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A 025	Continued From page 9 A review of resident #7 record revealed she was admitted on . She lived in the memory care unit. Her record contained an 1823 dated . Her diagnoses included , , , and right , . She required assistance with toileting and . On at 5:45pm Nurse (I) documented at 1:30pm resident found on the floor lying on the right side next to dining room table. The resident complained of right and , , . She was transferred to the hospital. On nurse (A) documented a review of an incident. Resident #7 had a on at 1:30pm. Stood up from her wheelchair in dining room and to the floor. She her right . Resident begin , , , . On at 5:40pm in an interview with Nurse A she confirmed the finding. Requested the facility policy from the . She provided an Incident Policy. She confirmed the facility did not have a policy for . She could not provide resident specific mitigating interventions for residents 1, 3, 5, 6, or 7. (Photo Evidence Obtained) Class II	A 025		