

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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 7/23/2012 the Assisted Living Facility (ALF) with Limited Nursing Services (LNS) re-licensure survey at Southland Suites of Melbourne located at 2680 Croton Road Melbourne, Florida 32935. The ALF had deficiencies found at the time of the visit.	A 000			
A 055	58A-5.0185(6) FAC Medication - Storage and Disposal (6) MEDICATION STORAGE AND DISPOSAL. (a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their rooms or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the rooms or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if: 1. The facility administers the medication; 2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request; 3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed; 4. The resident fails to maintain the medication in a safe manner as described in this paragraph; 5. The facility determines that because of physical arrangements and the conditions or	A 055			

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6950

1UDX11

If continuation sheet 1 of 10

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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 055	Continued From page 1 habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or 6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C. (b) Centrally stored medications must be: 1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, _____, or area at all times; 2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked; 3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and 4. Kept separately from the medications of other residents and properly closed or sealed. (c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident's representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident's request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked "discontinued medication." Such medication may be reused if re-prescribed by the resident's health care provider. (d) When a resident's stay in the facility has ended, the administrator shall return all	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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 055	Continued From page 2 medications to the resident, the resident ' s family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may disposed of in accordance with paragraph (e). (e) Medications which have been abandoned or which have expired must be disposed of within 30 days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness. (f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure that centrally stored medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, or area at all times. Findings: During the tour of the facility on : at approximately 10:15 AM; there were three residents sitting in wheelchairs the common area on the 1st floor . Further observations revealed there was a . had the medication cart that was across from the common area next to the dining . The medication cart was observed to be unlocked at the time. After entering the . drawers on the cart were pulled opened and there were medications in the	A 055			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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 055	Continued From page 3 cart, on top of the medication cart was the Medication Observation Record book that was also opened with a list of a resident's medications exposed. A staff member was observed on the other side of the hall at another medication cart. Interview with the staff at approximately 10:20 AM revealed that she was a Licensed Practical Nurse and she was going to give medications to a resident. She was asked at the time who was responsible for the medication cart that was in She stated that she was, she was informed that the door was opened and the medication cart was unlocked. She stated that she thought she had closed the door. Class III	A 055			
A 083	58A-5.0191(4) FAC Training - First Aid and (4) FIRST AID AND A staff member who has completed courses in First Aid and and holds a currently valid card documenting completion of such courses must be in the facility at all times. (a) Documentation of attendance at First Aid or course offered by an accredited college, university or vocational school; a licensed hospital; the American Red Cross, American Association, or National Safety Council; or a provider approved by the Department of Health, shall satisfy this requirement. (b) A nurse shall be considered as having met the training requirement for First Aid. An emergency medical technician or paramedic currently certified under Part III of Chapter 401, F.S., shall be considered as having met the training requirements for both First Aid and	A 083			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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 083	Continued From page 4 This Statute or Rule is not met as evidenced by: Based on personnel record review and interview the facility failed to ensure that a staff member who had completed courses in First Aid was in the facility at all times, which placed the frail, elderly residents of the facility who may require first aid treatment at risk for further harm. Findings: During personnel record review on _____ at approximately 12:30 PM for Staff B who worked the 3 PM-11 PM shift and Staff C who worked the 11 PM-7 AM shift revealed that there was no documentation in their records to confirm they had completed a First Aid Course. The Business Office Director was asked to provide documentation of a completed course in First aid for a staff member that was scheduled to work the 3 PM-11 PM shift and the 11 PM-7 AM shift for the day. She stated after searching, that none of the staff that were scheduled for the day that worked the above shifts and documentation of completion of a course in first Aid. Review of the staff schedule revealed the same staff that was scheduled to work for the day also worked _____ and none of them had evidence of the completion of a First Aid course. The Business office director stated at approximately 1:30 PM that none of the staff that was scheduled to work the 11 PM-7 AM for the day had documentation to confirm the completion of a First Aid course. She stated that she thought when they took the _____ course the first aid was included.	A 083			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE		STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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 083	Continued From page 5 The Director of Nursing stated at approximately 1:45 PM that all of the 11 PM-7 AM staff was newly hired. Review of the schedule revealed the same staff always worked the 11 PM-7 AM shift and none of them had evidence of the completion of a First Aid course. The facility was given the opportunity to provide to the agency via e-mail, documentation that the staff that worked the 3 PM-11 PM and 11 PM-7 AM shift had previously completed a first aid course to ensure that in the event that a resident of the facility experienced an illness or injury that required first aid treatment, a staff would have been present who was trained. A fax was received from the facility on _____ that included documentation to confirm that there was staff that worked on the 3 PM-11 PM that had a current valid First Aid Card, however there was no documentation to confirm that any of the staff that worked the 11 PM-7 AM shift had completed a course in First Aid until _____ which left the residents of the facility at risk for further harm if they experienced an emergency requiring first aid treatment and there was no staff available to provide the potential life saving techniques. Class II	A 083		
A 093	58A-5.020(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The Tenth Edition Recommended Dietary Allowances established by the Food and Nutrition	A 093		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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 093	Continued From page 6 Board - National Research Council, adjusted for age, sex and activity, shall be the nutritional standard used to evaluate meals. Therapeutic diets shall meet these nutritional standards to the extent possible. A summary of the Tenth Edition Recommended Dietary Allowances, interpreted by a daily food guide, is available from the DOEA Assisted Living Program. (b) The recommended dietary allowances shall be met by offering a variety of foods adapted to the food habits, preferences and physical abilities of the residents and prepared by the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the recommended dietary allowances to be made available to each resident daily by the facility are as follows: 1. Protein: 6 ounces or 2 or more servings; 2. Vegetables: 3 5 servings; 3. Fruit: 2 4 or more servings; 4. Bread and starches: 6 11 or more servings; 5. Milk or milk equivalent: 2 servings; 6. Fats, oils, and sweets: use sparingly; and 7. Water. (c) All regular and therapeutic menus to be used by the facility shall be reviewed annually by a registered dietitian, licensed dietitian/nutritionist, or by a dietetic technician supervised by a registered dietitian or licensed dietitian/nutritionist, to ensure the meals are commensurate with the nutritional standards established in this rule. Portion sizes shall be indicated on the menus or on a separate sheet. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences. This review shall be documented in the facility files and include the signature of the reviewer, registration or license number, and date	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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 093	Continued From page 7 reviewed. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents. (d) Menus to be served shall be dated and planned at least one week in advance for both regular and therapeutic diets. Residents shall be encouraged to participate in menu planning. Planned menus shall be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, shall be kept on file in the facility for 6 months. (e) Therapeutic diets shall be prepared and served as ordered by the health care provider. 1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items which enable residents to comply with the therapeutic diet shall be identified on the menus developed for use in the facility. 2. The facility shall document a resident's refusal to comply with a therapeutic diet and notification to the resident's health care provider of such refusal. If a resident refuses to follow a therapeutic diet after the benefits are explained, a signed statement from the resident or the resident's responsible party refusing the diet is acceptable documentation of a resident's preferences. In such instances daily documentation is not necessary. (f) For facilities serving three or more meals a day, no more than 14 hours shall elapse between the end of an evening meal containing a protein food and the beginning of a morning meal. Intervals between meals shall be evenly distributed throughout the day with not less than	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE			STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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 093	Continued From page 8 two hours nor more than six hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks shall be offered at least once per day. Snacks are not considered to be meals for the purposes of the time between meals. (g) Food shall be served attractively at safe and palatable temperatures. All residents shall be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, shall be on hand. (h) A 3-day supply of non perishable food, based on the number of weekly meals the facility has contracted with residents to serve, and shall be on hand at all times. The quantity shall be based on the resident census and not on licensed capacity. The supply shall consist of dry or canned foods that do not require refrigeration and shall be kept in sealed containers which are labeled and dated. The food shall be rotated in accordance with shelf life to ensure safety and palatability. Water sufficient for drinking and food preparation shall also be stored, or the facility shall have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure they had a 3 day emergency supply of milk. Findings: During the entrance interview at approximately	A 093			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER SOUTHLAND SUITES OF MELBOURNE		STREET ADDRESS, CITY, STATE, ZIP CODE 2680 CROTON ROAD MELBOURNE, FL 32935		
(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)	
A 093	Continued From page 9 9:30 AM the administrator stated the census was 75 residents. Resident record review that included contracts for residents #1 and #2, at approximately 1 PM revealed that the facility would provide 3 meals and a snack daily. Review of the emergency food supply on _____ at approximately 1 PM revealed there was no milk available. Based on a census of 75 residents the amount of milk needed was 75 residents x 0.5 quarts x 3 days = 112.5 quarts. Interview with the kitchen staff on said date and time revealed there was no milk available. The staff explained that they had milk, but it expired and was discarded. She further stated we will reorder milk before hurricane season. Class III	A 093		
N 000	INITIAL COMMENTS 7/23/_____ the Assisted Living Facility (ALF) with Limited Nursing Services (LNS) re-licensure survey at Southland Suites of Melbourne located at 2680 Croton Road Melbourne Florida 32935. The facility had no deficiencies found at the time of the visit, pertaining to LNS, deficiencies were cited under the ALF.	N 000		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Southland Suites Of Melbourne
2680 Croton Road
Melbourne, FL 32935

Dear Administrator:

Re: Relicensure Survey with LNS

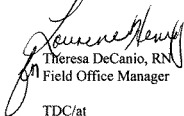
This letter reports the findings of a state licensure survey that was conducted on . 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after . 2012 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at (407) 420-2502.

Sincerely,



Theresa DeCanio, RN
Field Office Manager

TDC/at

Enclosure: State Form

