STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965743	10/19/2015
NAME OF PROVIDER OR SUPPLIER **FAMILY EXTENDED CARE OF MELBOURNE, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4001 STACK BOULEVARD MELBOURNE, FL 32901**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

#2015009677

A complaint investigation (CCR 2015009677) was conducted at Family Extended Care of Melbourne, Inc. survey on / / in conjunction with the biennial relicensure survey and a revisit. Family Extended Care of Melbourne, Inc. had deficiencies at the time of the investigation.

0025 Resident Care - Supervision

Based on Medication Observations Record (MOR) review, record review and interview the facility did not ensure: 1. When 1 of 7 sampled residents (#7) had a with a head injury she was immediately sent out to the hospital and 2. Ensure 4 of 7 sampled residents (#1, 4, 8 & 11) accepted for admission received care and services appropriate to meet their needs including following physician orders for medications.

Findings:

1. A Family extended care change in resident condition report for resident #4 noted : At 7:35 AM / -Walked inside resident give her med and noticed she had on her left side of her head and that was when she told me she last night, without saying anything to anybody.

During an interview with the Resident #4's Family member on / / at approximately 3:30 PM, he stated a staff from the facility called him between 5 AM-6 AM informing him that Resident #4 had fallen overnight and did not report it to anyone. He stated all the staff would tell him; was that she had on her head and he needed to come to make a decision as to whether she should go to the hospital. He stated he was in another town and it took him almost 3 hours to get to the facility. He stated once he arrived, he observed dried on the side of her head, she had and was not acting like herself. He told them to call 911 and he followed behind them in his car. He stated the resident was treated at the hospital, there was nothing wrong and she was brought back to the facility. He stated he was very upset after he knew everything was alright with his mother. He stated the facility tried to put it on him to make the assessment. He did not know why the staff could not assess her and had to wait for him to arrive before they could make a decision to send her to the hospital.

A telephone interview was conducted with the caregiver that found Resident #4 on at approximately 4:30 PM, she stated she was the person that called Resident #4's family member when she observed the on the resident's head. She stated when she called the family member, he told her to wait until he got there to see if she should be sent out via 911 or by non-emergency ambulance. She stated it took him a long time to get there. The staff continued to check on the resident until the family member arrived. She stated the family member went to the stayed for a while and then came to tell them that they needed to call 911. They called 911 and she was sent out. She stated there was no nurse on duty to assess the resident.

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The resident sustained a head injury and according the family member it took him almost 3 hours to get the facility. There was no nurse present at the facility and the staff did not immediately send the resident out to hospital to get medical attention until the family member arrived.
During an interview with the administrator on / at approximately 5:20 PM she stated the staff would call the family and give them the option of calling 911 or having non-emergency ambulance transport them to the hospital, if the illness or injury was something minor. She stated for a head injury, the resident should have been sent out immediately, there was no nurse on duty and unlicensed staff could not make assessments.
2. During an interview with Resident #7 on / at approximately 11 AM, she stated she did not get her eye drops as ordered and the health care provider was very surprised when she went for her revisit after her eye surgery that the pressure in her eye was worse.
Record review for Resident #7 revealed an Health Care provider's order dated / that noted (for) 0.2-0.5% 1 drop three times a day in the right eye
1 drop in right eye at breakfast
1 drop in right eye at lunch
1 drop in right eye at dinner
The health care provider noted as follows:
"**ALL MEDICATIONS MUST BE GIVEN AS SCHEDULED**"
The Medication Observation Record (MOR) for noted the was given twice daily at 9:30 AM and 9 PM on 10/7, 10/8, / , / , and . On 10/9 it was only given at 9:30 AM. At 9 PM on / the staff's initial was circled and noted at 9:42 PM- "Resident refused to take at this time. She stated that it is late. Was to be given after every meal. Schedule time on MOR is 9 PM."
The medication was not given three times daily as ordered until / .

During an interview with the resident care director on at approximately 3 PM, she stated the pharmacy stated they did not change the electronic MOR's in their computerized system, the staff could not document the medication 3 times daily and they continued to give the medication twice until the pharmacy changed the computerized MOR's. The resident director was informed at the time that a handwritten MOR could have been used until the pharmacy changed the order in the computerized system, to ensure the resident received her medications as ordered.

During an interview with the administrator on / at approximately 5:15 PM, she stated the pharmacy did not change the MOR's, she stated as soon as they received the order they staff faxed it to the pharmacy. She stated she did not know why it took the pharmacy so long to change the MOR.

3. The Agency received information that indicated resident #1's physician order for (for pain) patch was not followed.

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Resident record review revealed an 1823 dated / that indicated diagnoses of , and . The resident needed assistance with self-administration of medications.

Review of the physician order dated / Patch 12.5 milligrams (mg)/every 72 hours.

Review of MOR for 2015 indicated apply patch 12.5 mg/72 hours. The patch was charted as given on and at 9 AM, initials were in the box.

Review of Controlled Substance Sheet for 2015 revealed 17.5 milligrams (mg) was charted as given on / at 8:01 AM, 5 patches were on hand, amount received "error" was documented, amount given 1 and amount remaining was 4. On at 8 AM, the amount on hand was 4, amount given was 1 and amount remaining was 3.

The patch was changed in 24 hours. There was no documentation to review that indicated the reason the patch was changed in less than 72 hours.

In an interview with the administrator on / at approximately 5 PM who stated the staff who placed the patches on the resident, no longer worked in the facility. She also stated the resident did not have a patch on her on . She did not know what happened to the patch that was charted on / .

4. In an interview with resident # 8 on / at approximately 10:30 AM, who stated "Well the medications were a little mixed up. Last week I had . They were supposed to give me a pill for , but they did not. The nurse was supposed to check and there was no order. It was . They gave me a little pill to calm me down. I don't know what it was."
Resident record review for resident # 8 revealed a health assessment report form 1823 dated / / that listed diagnoses of , , , hip pain, , debility, tremors, and high , .
Prescription dated / / indicated (for) start 4 mg one time, then 2 mg after each loose stool max 16 mg.
Review of the 2015 Medication Observation Record (MOR) revealed that Lorapemide ( ) 2 mg take 2 capsules (4 mg) for first dose. Then 1 capsule after each loose stool. The MOR was blank and there were no written notations that the medication was offered to the resident, she refused or no longer had .
The 2015 MOR also listed D3 5,000 unit capsule take 1 tablet by mouth once a week. The original prescription date was . The MOR indicated the medication was given on only. The MOR was blank and there were no written notations that the medication was offered to

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the resident and that she refused.
In an interview with the administrator on / / at approximately 4 PM, who stated it was her understanding the resident did not have .
5. In an interview on at approximately 11 AM with resident #11 and her family member who stated, "They wake my (family member) at 5 AM to give me a pill. I don't know what it is, they don't tell you, only if you ask. We have medications after 9 AM, they wake you for that too. We asked they stop. Then there are more medications in the morning and evening".
Resident record review revealed a health assessment report 1823 dated that listed diagnoses of , high , and . She needed assistance with self -administration of medications.
A prescription dated indicated (hormone) 88 micrograms (mcg) daily at 900 (9 AM). A prescription dated indicated (supplement) 600 mg one twice daily.
Continued review revealed the 2015 Medication Observation Record (MOR) listed 600 mg one twice daily and was given at 5 AM and 9 AM from to / . 88 mcg daily at 9 AM was given daily.
The 2015 MOR listed 600 mg one twice daily and was given at 5 AM and 9 AM from to / (survey date). 88 mcg daily at 9 AM was given daily.
Observations on / / at approximately 4:30 PM noted the prescription label dated / indicated 88 mg take 1 tablet 30 minutes before breakfast. There were 2 yellow notices pasted to the bottle. One indicated, take this medication 4 hours before taking , or products containing , iron or . The other indicated it was very important that you take the medication as directed.
In an interview with the administrator on / at approximately 4 PM,who stated she would speak with the staff.
In an interview with the personal care manager on / / at approximately 4:30 PM, who stated she was not aware that resident #11 was being awakened for a pill. She could change that. She did not know why she took a pill at 5 AM and another at 9 AM along with the .
Class III

0030 Resident Care - Rights & Facility Procedures

Based on record review and interview the facility failed to ensure the resident's rights were honored for 1 of 7 sampled residents (#5).
Findings:
Resident record review for resident #5 that included the resident agreement revealed a "rider" signed by a witness and the resident on / . The rider indicated "For low and moderate income residents only". The rights under this residency agreement shall terminate immediately, and Century Oaks shall have the right to evict resident immediately if the resident fails to qualify as an individual or family or low or moderate income.

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In an interview with the administrator on / / at approximately 3 PM, who confirmed the findings.
Class III

0056 Medication - Labeling and Orders

Based on record review and interview the facility failed to ensure medications were filled in a timely manner for 1 of 7 sampled residents (#4).

Findings:

Resident record review for #4 revealed an 1823 dated / that indicated diagnoses of , and . The resident needed assistance with self-administration of medications.

Review of the physicians' orders dated / / , / and / revealed , Patch (for pain) 12.5 milligrams (mg)/every 72 hours.

Review of MOR for 2015 indicated apply patch 12.5 mg/72 hours. The patch was started on at 9 AM, initials were in the box.

There was no documentation to review that indicated the reason the patch was started 12 days after it was ordered.

In an interview with the administrator on / / at approximately 5 PM who stated the patch was ordered on several different dates. She was not aware of the reason the patch was not started in a timely manner.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Family Extended Care Of Melbourne, Inc
4001 Stack Boulevard
Melbourne, FL 32901

RE: CCR #2015009677

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

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