STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965743	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY EXTENDED CARE OF MELBOURNE, INC	**4001 STACK BOULEVARD MELBOURNE, FL 32901**

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

0000 Initial Comments

A revisit to complaint investigation # 2016004618 was conducted at Family Extended Care of Melbourne, Inc. on . Family Extended Care license #10095 had deficiencies at the time of the visit.

0025 Resident Care - Supervision

Based on interviews and record review the facility did not provide care and services appropriate to the needs of residents accepted for admission to the facility and did not make sure healthcare provider orders were followed for 2 of 6 sampled residents (#2 and #23).

Findings:
Record review for resident #2 revealed she had diagnoses of anorexia and and she required assistance with self- administration of her medications. She lived in the secure memory care unit.

Record review for resident #2 revealed the health care provider orders dated for Ensure (dietary supplement) drink 1 can by mouth twice daily and to drink 1 glass of yellow Gatorade once a day. Her 2016 MOR listed ensure at 9 AM and 5 PM and Gatorade at 9 AM. The MOR was blank from 9/5- . There were no notations on the MOR that indicated why those dates were blank.
During an interview with the administrator on at 12:45 PM, she said they do not have the ability to sign electronically on the MOR for orders that are for Your Information (FYI) and she said they did not have documentation elsewhere to indicate the resident received the drinks.
During an interview with the resident on at 1:00 PM, she said she drank the Ensure and Gatorade almost daily but not quite every day.
During an interview with the administrator and the nurse on at 1:15 PM, the nurse said the resident did not drink them every day and sometimes she did not drink all of it.

Resident record review for resident #23 revealed a health assessment report 1823 dated / that listed diagnosis of high accident ( ) - ( ), and gait . He needed assistance with self-administration of medications. A prescription dated / / indicated 10 milligrams (mg) every 6 hours as needed for greater than 160. The review revealed the 2016 and the 2016 Medication Observation Records (MOR) listed 10 milligrams (mg) every 6 hours as needed

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

for , , greater than 160 and were blank from / to / and from to . There was no evidence the resident's was taken every 6 hours by a licensed nurse to determine if the resident needed the medication or not.
In an interview on at 12:30 PM the administrator said the facility did not do medications that required parameters or medications to be taken as needed/as necessary and would refer to home health care or get order to discontinue the medication. She added that after she researched she did not locate an order for home healthcare. She provided a fax submitted to the healthcare provider dated which indicated "need discontinue (d/c) order for facility does not perform parameters".
Class

0054 Medication - Records

revisit conducted. Deficiency A-054 remained uncorrected.

Based on record review and interview the facility did not keep an up to date Medication Observation Record (MOR) for 1 of 6 sampled residents (2).

Findings:

Record review for resident #2 revealed health care provider orders dated / for ensure drink 1 can by mouth twice daily and to drink 1 glass of yellow Gatorade once a day. Her 2016 MOR listed ensure at 9 AM and 5 PM and Gatorade at 9 AM. The MOR was blank from 9/5- . There were no notations on the MOR that indicated why those dates were blank.
During an interview with the administrator on / at 12:45 PM, she said they do not have the ability to sign electronically on the MOR for orders that are for Your Information (FYI) and she said they did not have documentation elsewhere to indicate the resident received the drinks.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11965743 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY EXTENDED CARE OF MELBOURNE, INC	4001 STACK BOULEVARD MELBOURNE, FL 32901

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0031 Reg. # 58A-5.0182(7) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) [signature]	DATE 10/5/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/13/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

RE: Revisit to #2016004678

Dear Administrator:

This letter reports the findings of a complaint investigation revisit survey conducted on 27, 2016by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

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. Should you have any questions please call this office at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

BBT7

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