STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964343	**11/29/2016**
NAME OF PROVIDER OR SUPPLIER **SOLARIS SENIOR LIVING AT MERRITT ISLAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **535 CROCKETT BLVD.** **MERRITT ISLAND, FL 32953**	

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

0000 - Initial Comments

Complaint Investigation #2016010955 was conducted on . Solaris Senior Living Merritt Island, License #8975, had deficiencies at the time of the visit.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility did not ensure that as part of the continued residency criteria, 1 of 5 residents had a face-to-face medical examination by a health care provider at least every 3 years after the initial assessment (#1).
Findings:
Resident #1's record revealed she was admitted to the facility on . The health assessment form 1823 was dated . There was no evidence a health assessment was conducted 3 years after her admission.
On at 3:10 PM, the administrator confirmed the finding.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and interviews, the facility failed to provide care and services appropriate to the needs of 1 of 5 sampled residents, and did not ensure medications were given without errors (#2).

Findings:

The 1-Day Adverse Report, dated , indicated that during a medication pass, a nurse left another resident's medications in an area where anyone could take the medication and went to assist resident #2. Resident #2 went to where the nurse put down the medications and took the medications meant for another resident, 6 milligrams (mg.) used for , , 100 mg., an anti-convulsant, and , 75 mg., an anti-depressant. Resident #2 was then transferred to the hospital for evaluation and returned approximately 2 and 1/2 hours later. The hospital discharge summary indicated that the medication ingested had not caused any adverse effects. Resident #2 was to follow-up with her regular doctor as necessary/needed. The 15-Day Adverse Report, dated , indicated resident #2 was transferred to the hospital because of a medication error. Per the report, a pharmacist did a review of the medications taken by mistake and the current resident's medications. They concluded that no adverse issues would arise from the error and dose involved.

Another 1-Day Adverse Report, dated , indicated resident #2 "suffered acute myoclonic activity secondary to drug interactions. Myoclonus is "a brief, involuntary twitching of a muscle or group of

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muscles...." (wikipedia.com). The 15-Day Adverse Report, dated , indicated the facility started to give resident #2 her medications. The resident had been self-administering medication since admission to the facility and was taking , 3 mg. at bedtime. The original order was for 3 mg. 3 times a day, as needed. The order was changed to 1 mg. at bedtime and 0.25 mg. at 3 AM/as needed. The report read, "We had sent her to the hospital with a high concern of possible myoclonic due to withdraw form order changes." The report indicated the hospital Risk Manager felt the matter was documented incorrectly and the facility filed for an update of records to reflect the correct information. The facility pharmacist believed the withdrawal from benzodiazepines could include tremors and . The report indicated the facility should have noticed the resident's , should have been a gradual decrease.

Facility note dated at 10:45 PM indicated a nurse stopped to give resident #2 her sleeping medication but on the way to another resident, resident #2 asked the nurse to check her fan. When the nurse turned her back, resident #2 went to the kitchen and took someone else's medications. Resident #2 was sent to the emergency (ER).

On , resident #2 was seen in the ER. The history and physical, dated , indicated diagnoses including myoclonus secondary to drug ingestion. The resident was admitted for observation and discharged on .

Health assessments reports dated , and indicated resident #2 needed someone to assist her with medication administration. The diagnoses listed included . She was partially and forgetful.

On at 10:20 AM, resident #2 said on the day she took the wrong medication and had to be sent to the hospital, the nurse came into her bring her medicine but "she didn't tell me where my pills were." The resident said she did not realize the nurse placed her own medications in front of her because she was . She said the nurse placed something like a shoe box down in her kitchen. She said she asked the nurse to look at her fan and while the nurse was doing that, the resident asked the nurse, "Do you want me to take all of these?" She said the nurse replied "yes". When the nurse came into the kitchen area and realized the resident took the wrong medications, she told the resident she would have to go to the hospital and be checked out.

On at 3:30 PM, the administrator stated the nurse pre-poured some medications, which was against regulation, and placed them in a plastic tray. She went to see resident #2. She placed the medication for resident #2 on the table and place the tray by the kitchen. While she adjusted the resident's fan, she told the resident to take her medications. The resident went to the kitchen and took

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what she thought were her medications. He said the resident had been self-administering her sleep medications. The facility started giving the medications in 2016 because she was over-medicating.

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on record review and interview, the facility failed to make sure that adequate and appropriate health care consistent with established and recognized standards within the community was provided to 1 of 5 sampled residents (#3).

Findings:

The 1-Day Adverse Report dated revealed resident #3 "suffered a and.... instead of calling 911, the LPN (licensed practical nurse) called non-emergency transport to take the resident to the hospital for (evaluation)."
The 15-Day Adverse Report dated indicated the circumstances of the incident were that resident #3 suffered a , per hospital treatment and diagnoses. The staff failed to notice the importance of using emergency transport versus using non-emergency transportation after finding the resident and noting signs that should have alerted staff. Per the report, on at approximately 7:15 AM, resident #3 was found on the floor by a resident attendant (caregiver) and called the nurse. The nurses assisted the resident off the floor and noticed a "(twisted jaw) a sign of possible stoke." They (staff) decided to call transport (non-emergency) to take the resident to the Emergency (ER). At a later time, while awaiting transportation, they (staff) noticed signs (of stoke) but decided they would wait for the local transport to take the resident to the hospital.

Facility note dated time not noted, indicated resident # 3 was found on the floor by a certified nursing assistant (CNA) this morning. The resident stated she . The resident voiced no complaints of discomfort. She had a scrape to the right knee, on the right inner , and a to the left . The CNA noticed the resident's jaw was not aligned. The resident was sent by non-emergency transportation to the ER.

Health assessment report 1823 dated listed diagnoses including , , , accident with left hemi-paresis, trans- , , , high , , , and memory loss.

Adult Protective Services report dated indicated the resident was found on the floor, had left

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side , was /dazed and her jaw was not aligned. The facility nurse called non-emergency transportation at approximately 8:30 AM, and the resident arrived at the hospital at approximately 10 AM.

On at 3:30 PM, the administrator stated the LPN failed to call 911 and called non- emergency transportation. Later on, the nurse noted the jaw was not aligned, so she called 911 but since non-emergency transportation was at the facility, the non-emergent team took the resident to the hospital.

"The evaluation and initial treatment of patients with should be performed expeditiously. Because time is critical, a limited number of essential diagnostic tests are recommended." (American Association, 2013). "As emergency medical services offers the promptest care, all patients with the acute onset of symptoms should use services such as telephoning 911...." (medscape.org/Vega). "Emergency treatment starts in the ambulance. The emergency workers may take you to a specialized hospital to ensure that you receive the quickest possible diagnosis and treatment." (cdc.gov/2014).

Class II

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the facility did not keep an up to date Medication Observation Records (MORs) for 3 of 5 sampled residents (#1, 2 & 6).

Findings:

1. Resident #1's record revealed a health assessment form 1823 dated that reflected she required medication administration.
The 2016 MOR revealed the following:
1000 micrograms (mcg.) per 1 milliliter (ml.) inject 1 ml. ( ) once a month. The 5 PM dose on was blank.
20 milligrams (mg.) one capsule by mouth (PO) every morning. The 6 AM doses from through were blank.
20 mg. 1 tablet PO daily. The 9 AM dose on was blank.
600 mg. 1 tablet PO twice daily ( ). The 9 AM and 5 PM doses on were blank.
The 2016 MOR revealed the following:
1000 mcg. per 1 ml., inject 1 ml. once a month. The 5 PM dose on was blank.
20 mg. 1 tablet PO daily. The 9 AM dose on was blank.

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D3 1,000 international units 1 tablet PO daily. The 9 AM dose on was blank.
600 mg. 1 tablet PO . The 5 PM dose on , , , were blank. The 9 AM dose on was blank.
On at 3:10 PM, the administrator confirmed the above findings.

2. Resident #6's record revealed a health assessment form 1823 dated that read she required medication administration.
The 2016 MOR revealed the following:
D2 50,000 units one capsule PO every week. The 9 AM dose on was blank.
50 mg. one capsule PO . The 9 AM and 5 PM doses on were blank.
15 mg. one tablet by mouth . The 9 AM and 9 PM doses on were blank.
Pradaxa 75 mg. 1 capsule PO . The 9 AM dose on and were blank. The 5 PM dose on and were blank.
25 mg. 1 tablet PO . The 9 AM dose on was blank. The 5 PM dose on was blank.
On at 3:10 PM, the administrator confirmed the above findings.

3. Health assessments reports dated , and indicated resident #2 needed medication administration. The diagnoses listed included . She was partially and forgetful.
The 2016 MOR revealed the following:
1 mg. at bedtime (HS) was blank on , , and .
125 mcg. at 6 AM was blank on .
Inhaler Solution every 6 hours was blank on at 1 PM on , , , , and . The 9 PM dose was blank on , , , , , , , and .
Lorsatan 100 mg. daily at 9 AM was blank on .

The back page of the MOR did not have any notations to explain the blank spaces on the MOR. There were notations that documented the resident either refused the medications, if she was out of the facility or if the medications were on hold.

On at 3 PM, the administrator confirmed the above findings. At 3:45 PM, he said he had no further documentation to explain why the above medications were not signed as given by staff.

Class III

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0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observations and interviews, the facility failed to separate discontinued medications from medications in current use for centrally stored medications, and failed to mark the area in which the discontinued medications were stored.

Findings:

On at 11:05 AM, the medications centrally stored by the facility revealed a cabinet that contained plastic bins filled with medication containers. The director of nursing said the medications were discontinued but stored with current medications. She confirmed the discontinued medications were not separated from the current medications, and the area that contained discontinued medications was not marked.

On at 3:10 PM, the administrator said, "I didn't know we had to keep them separated."

Class III