STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968235	**07/06/2017**
NAME OF PROVIDER OR SUPPLIER **DISCOVERY VILLAGE AT MELBOURNE**	STREET ADDRESS, CITY, STATE, ZIP CODE **3260 N HARBOR CITY BLVD** **MELBOURNE, FL 32935**	

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

0000 - Initial Comments

A complaint investigation(s) #2017003871 and #2017003856 were conducted on and . Discovery Village at Melbourne, license #12122, had deficiencies at the time of the investigation related to complaint #2017003871.

There were no deficiencies related to complaint #2017003856.

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

Based on record reviews and interview the facility failed to ensure a new health assessment form 1823 was completed for 1 of 5 sampled residents (#3) who had a significant change.

Findings:

Record review for resident #3 revealed that her most recent health assessment form 1823 was dated on .

She was admitted to hospice services on . There was no evidence that a new 1823 was completed when she was admitted to hospice, as required.

During an interview with the director of nursing on at 3:13 pm, she confirmed the finding.

Class III

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

Based on record reviews and interviews the facility failed to provide safe, adequate, and appropriate health care for 2 of 5 sampled residents (#2 and #5) and failed to maintain a safe and clean living environment for 1 of 5 sampled residents (#4.)

Findings:

1. Record review for resident #5 revealed a health assessment form 1823 that was dated that indicated she had an to . Her record contained an order from a health care provider that was dated for 500 milligram tablets, take 1 tablet orally twice a day for 10 days.

Review of her , 2017 Medication Observation Record (MOR) revealed the entry for was signed as given twice on at 1pm and 8pm and once on at 8am. The MOR did not indicate that

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she had an to .

During an interview with staff A, a licensed nurse, on at 1:12 pm, she said she administered the medication to resident #5 on at 8am and that she was unaware that resident #5 was to .

2. Record review for resident #2 revealed a health assessment form 1823 that was dated and that indicated she had a diagnoses of .

A facility note that was dated on at 10 pm indicated the staff reported that she had four episodes of loose stools.

Her record contained no evidence to indicate that a health care provider was notified when she had four loose stools.

On at 2:30 pm, she had a very loose foul smelling stool. A fax was sent to a health care provider with a request made to conduct a stool test for (,) a bacterium that can cause symptoms ranging from to life-threatening of the (mayoclinic.org.) A note indicated that the staff would await a response.

A hospice note that was dated on indicated that the facility staff reported that resident #2 had loose stools.

On at 2 pm, she had very loose stool with and an extremely foul smelling odor for several days. A fax was sent to a health care provider and the note indicated that the facility would await a response.

Her record contained no evidence to indicate that in addition to a fax being sent to a health care provider, a phone call was made to follow up.

On , a hospice note indicated that the facility staff reported five foul smelling loose stools on the previous night and two on that morning.

On , the hospice nurse obtained an order from the health care provider to check the resident's stool for . A facility note indicated that she continued to have loose, , and foul smelling stool.

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On at 2:25 pm, the lab called the facility and reported that her stool was positive for and at 5:15 pm, she was transferred out of the facility to a hospice inpatient unit.

On , a hospice note indicated that she was at the inpatient hospice unit because the facility was unable to keep her because the facility did not have an isolation area.

During an interview with the memory care director on at 2 pm, she said she did not know why a health care provider was not notified when resident #2 had four loose stools on . She further stated she did know why a health care provider was not called when resident #2 continued to have loose stools and the facility suspected she had .

3. During an interview with staff B on at 9:59 am, she said when resident #2 had in , 2017, she shared a resident #4.

A facility note that was dated on at 10 pm indicated that the staff reported that resident #2 had four episodes of loose stools.

On at 2:30pm, resident #2 had a very loose foul smelling stool. A fax was sent to a health care provider with a request made to conduct a stool test for . A noted indicated that the staff would await a response.

On , a hospice note indicated that the facility staff reported that resident #2 had loose stools.

On at 2pm, resident #2 had very loose stool with and an extremely foul smelling odor for several days. A fax was sent to a health care provider and the note indicated that the staff would await a response.

On , a hospice note indicated that the facility staff reported that resident #2 had five loose stools on the previous night and two that morning with a foul odor.

On , the hospice nurse obtained an order from the health care provider to check the resident's stool for . A facility note indicated that she continued to have loose, , and foul smelling stool.

A facility note that was dated at 2:25 pm indicated that the lab called the facility and reported that the stool of resident #2 was positive for and at 5:15 pm she was transferred out of the facility to a hospice inpatient unit.

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During an interview with the director of nursing and memory care director on at 11:48 am, they said they called the health department on and they were told to clean the with bleach and water. They said housekeeping cleaned the residents #2 and #4 on . They said they both went to the facility on and cleaned the dining with bleach and water. The memory care director said resident #2 had foul smelling stool on . She was unaware that the staff reported resident #2 had four loose stools on .

The facility's control policy and procedure indicated that housekeeping duties were located on a duty list. Staff members were to bring areas concerning control to the attention of the administrator. were to be between uses by the residents and be thoroughly cleaned according to the schedule in the duty list.

During an interview with the director of facility operations on at 10:50 am, he said the facility did not have a list of duties for the housekeeping staff or a schedule for the resident to be cleaned. He said he just verbally told the housekeepers which to clean. He said he knew resident #2 had but was not sure, when her apartment was cleaned. He said a deep cleaning of the memory care unit took place daily after he learned resident #2 had on .

During an interview with staff B and staff C on at 12:40 pm, they both said that the apartment of residents #2 and #4 was not cleaned until after the stool test for resident #2 was positive for on . Staff B said the staff reported each time resident #2 had loose stools but they were told that the nurses were waiting on an order from the doctor.

There was no evidence to indicate that the facility took measures to prevent the spread of , including the shared apartment, until seven days after resident #2 began having loose stools and when she was diagnosed with on .

On at 1:40 pm, the director of nursing and the memory care director confirmed the findings.

Class III

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

Based on record reviews and interviews, the facility failed to maintain an updated Medication Observation Record (MOR) for 1 of 5 sampled residents (#5.)

Findings:

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SUMMARY STATEMENT OF DEFICIENCIES
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Record review for resident #5 revealed a health assessment form 1823 that was dated and that indicated she was to .

Her record contained an order from a health care provider that was dated on for , 500 milligrams orally twice a day for 10 days.

The page of her , 2017 MOR that contained the entry for , did not list any of her .

During an interview with the director of nursing on at 1:15 pm, she confirmed the finding.

Class III