STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964343	**12/07/2017**
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

The re-licensure survey with Limited Nursing Services (NS) was conducted on . Solaris Senior Living of Merritt Island, license #8975, had deficiencies at the time of the visit.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on the resident record review and interview, the facility failed to ensure that the AHCA 1823 form Health Assessment was completed entirely and accurate for 1 of 5 sampled residents (#4) and a health assessment form 1823 was not altered for 1 of 5 sampled residents (#3).

Findings:

1. Resident #4's record review revealed admission into the facility on , the 1823 Health Assessment form dated was not documented or not marked and did not answer question #5 in section C, page 2 regarding if the resident "require 24-hour nursing or , , care?".

On at 4 PM, an interview with the Director of Resident Services who stated she had a current 1823 Health Assessment for resident #4 completed from recent a hospitalization. However, the health assessment did not have a date the form was signed by the physician. The finding was confirmed.
2. Record review for resident #3 revealed a health assessment form 1823 signed by a health care provider and dated on . The section that described how much assistance resident #3 required with her Activities of Daily Living (ADLs) was altered. The markings that were in the assistance and supervision columns were crossed off and check marks were placed in the independent column for all of the ADLs.

The form contained no initials or any other documentation to indicate who made the changes to the form.

On at 3:38 pm, the nursing director confirmed the findings and said she was unaware of who altered the form.

Class III

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

Based on observations, record reviews, and interviews, the facility retained a resident (# 11) who had an unstageable , and exceeded the continued residency criteria in an Assisted Living Facility .

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SOLARIS SENIOR LIVING AT MERRITT ISLAND	**535 CROCKETT BLVD. MERRITT ISLAND, FL 32953**

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Findings:

On at 9 am, the nursing director identified resident #11 and said she had a , to her left heel. The nursing director described the as a deep tissue injury.

A deep tissue injury is defined as a purple or maroon localized area of discolored intact skin or -filled due to damage of underlying soft tissue from pressure and/or shear (wikipedia.org.)

On at 9:59 AM, observations made of the revealed the bed was moist and 95% of the bed was covered with yellow . In addition, there was black tissue on the edge of the bed from 1 o'clock to 5 o'clock. A home health registered nurse was present during the observation and said the appeared worse compared to her last visit on .

Record review for resident #11 revealed she was admitted to the facility on . Her diagnoses included left hip , Failure, and type 2. She was admitted to a rehabilitation facility on following a and a left hip and returned to the facility on . A physician's order from the rehabilitation facility dated on indicated she was to have soaked 4x4 gauze applied to a left heel deep tissue injury every day.

Her readmission health assessment form 1823 dated on indicated that soaked 4x4 gauze was to be applied to her left heel every day.

A home health certification and plan of care for the period of through indicated resident #11 had an unstageable , to her left heel. A health care provider signed the plan of care.

An unstageable , is defined as full thickness tissue loss in which actual depth of the is completely obscured by (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the bed. Until enough and/or eschar is removed to expose the base of the , the true depth, and therefore stage, cannot be determined (wikipedia.org.)

A home health note signed by a registered nurse and dated on indicated that resident #11 had an unstageable , to her left heel. A deep tissue injury was suspected and the bed was covered with black eschar.

A facility skin record completed on indicated that a care physician reclassified the left heel from unstageable to a .

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A home health certification and plan of care for the period of through indicated resident #11 had a to her left heel. A health care provider signed the plan of care.

A home health certification and plan of care for the period of through indicated resident #11 had an unstageable to her left heel. A health care provider signed the plan of care.

During an interview with the nursing director on at 3:30 pm, she confirmed the findings and said she thought the resident could reside in the facility since the doctor reclassified the .

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on record review and interview, the facility failed to have evidence showing that 4 of 5 sampled staff had received all the required in-service training within 30 days of employment (A, B, C & D).

Findings:

1. Review of the personnel record for Staff #A, a caregiver hired , revealed she had not received a minimum of 3 hours in-service training that covered resident behavior and needs and providing assistance with the activities of daily living. Further review for Staff A revealed no certificates for training in the following areas: 1) the facility's resident elopement response policies and procedures, 2) the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation, 3) incident reporting, 4) resident rights, 5) recognizing and reporting , neglect and , or 5) nutrition and safe food handling.

There was no evidence in the record that Staff A held a current CNA certification, and was not exempt from any of the above training.

2. Review of the personnel record for Staff B, a caregiver hired , revealed she had not received a minimum of 3 hours in-service training that covered resident behavior and needs and providing assistance with the activities of daily living. Further review revealed no certificates for training in the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

There was no evidence in the record that Staff B held current CNA certification, and was not exempt from any of the above training.

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In an interview with the Human Resource manager on at 3:30 PM, she confirmed she did not have documentation of training for these employees.
3. Personnel record review for Staff C hired revealed she provided personal care to the resident and there was no documentation to confirm she had received a 3 hour training on Resident behavior and needs and providing assistance with the activities of daily living. The training certificates available for training's related to the required training was for 1.75 hours. Further personnel record review revealed there was no documentation to confirm she had received training regarding the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

4. Personnel record review for Staff D hired revealed there was no documentation to confirm she had received training regarding the facility's emergency procedures including chain-of-command and staff roles relating to emergency evacuation.

On at 3:30 PM, the human resource staff confirmed the findings.

Class III

0082 - Training - / - 58A-5.0191(3) FAC

Based on personnel record review and interview, the facility failed to ensure that 1 of 5 direct care staff (#A) had completed a one-time education course on / (/) within 30 days of hire.

Findings:

Review of the personnel record for Staff #A, date of hire , revealed she was hired as a resident assistant. The record did not reveal documentation of training in / as required within 30 days of hire.

On at 3:30 PM, the Human Resources manager confirmed the training was not in the file and said she could not prove the training had been completed.

Class III

0090 - Training - - 58A-5.0191(11) FAC

Based on personnel record review and interview the facility failed to have evidence that 4 of 5 sampled staff (A, B , C and D) had at least one hour of training in the facility's policies and procedures regarding

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('s) that included information in Rule 58A-5.0186, F.A.C. within 30 days after employment.

Findings:

1. Personnel record review for Staff C hired and staff D hired revealed there was a 30-minute online training titled advanced directives located in their records. There was no documentation to confirm they received at least one hour of training on the facility's policies and procedures regarding ('s). This training would have included information in Rule 58A-5.0186, F.A.C. within 30 days after employment.

On at 3:30 PM, the human resource staff confirmed the findings

2. Personnel record review for Staff A, hired and Staff B, hired , revealed no documentation to confirm they received at least one hour of training on the facility's policies and procedures regarding ('s) within 30 days after employment.

On at 3:30 PM, the Human Resources manager confirmed the findings.

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

Based on observations and interviews, the facility failed to provide and maintain a home-like and decent environment in which to provide a safe living environment for 2 of 10 sampled residents' .

Findings:

Observations during the tour on at 9:45 AM revealed the ceiling tile in had brown stains and holes in them.

Observation on at 10 AM, revealed revealed the ceiling tile in also had brown stains.

On at 12:30 PM, the administrator confirmed the finding.

Class III

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N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC

Based on record reviews and interview, the facility failed to obtain an order from a health care provider for a resident (#12) who received a Limited Nursing Service (LNS).

Findings:

On at 9:30 am, the nursing director identified resident #12 and said he received LNS for , care.

Record review for resident #12 revealed an order from a health care provider dated on to change the , every 4 days with his shower.

Review of the 2017 LNS medication observation record for resident #11 revealed an entry to change his , every 3 days.

The record for resident #11 did not contain an order from a health care provider to change the frequency of his , care, as required.

On at 4 pm, the nursing director confirmed the findings.

Class III

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on the Agency Clearinghouse Website review and interview, the facility failed to register and maintain the employment status of all employees within the Agency's Background Screening Clearinghouse for 2 of 5 sampled staff employees (D &, E).

Findings:

Review of the Agency's Background Screening website for 5 sampled staff revealed that Staff D, hired , and Staff E, hired , were not on the clearinghouse roster for the facility.

In an interview with the administrator on at 4:00 PM, he confirmed the findings.

Unclassified