STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968235	**10/26/2017**
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 (#2017007244) was conducted on and . Discovery Village at Melbourne, license #12122, had deficiencies at the time of this investigation.

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

Based on record reviews and interviews, the facility failed to provide adequate supervision for 1 of 4 sampled residents (#3), and failed to follow health care provider orders for 1 of 4 sampled residents (#1).

Findings:

Review of FloridaHealthFinder.gov revealed the facility was an Assisted Living Facility with 155 licensed beds.

During the entrance on at 9 a.m., the director of nursing identified a portion of the facility that the facility considered independent living based on the residents who lived there did not require assistance.

1. Record review for resident #3 revealed an admission health assessment form 1823 dated on that indicated she was independent with her Activities of Daily Living (ADLs) and she did not require assistance with her medications. Her resident agreement was titled independent living.

Review of a health assessment form 1823 dated on indicated that she had a diagnoses of , , , , , , and a left .

A care note dated on on the 7 a..m. to 3 p.m. shift indicated that resident #3 was found on her living under a chair. She was with some mental clarity. She was naked and her disheveled. She was sent to the hospital.

An incident report indicated that on at 11:08 a.m., she was found on her floor with notable skin discolorations. She had no complaints of pain. The staff were notified of the incident by a worried neighbor. She was transported to the hospital.

A fax sent to a health care provider on indicated that she was found on the floor. The period of time was undetermined. She had slight with moments of clarity. She did not remember the . She had no open wounds. She had multiple areas of skin discoloration, pain on her left leg, and to her lower extremities. She was sent to the hospital.

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During an interview with resident #3 on at 10:10 a.m., she said a couple of months ago she had a . It seemed like she tripped and put her hands down which got the brunt of the . She got herself off the floor. She had a broken left wrist and she wore a , . The facility staff did not check on her because she was supposed to be independent. The staff did nothing for her care. She said she had an alert necklace but she was not wearing it at the time of the interview. She said she did not live at the facility when she , that she was outside. She was unable to provide any details related to the incident that occurred on .

During a phone interview with the son of resident #3 on at 11:40 a.m., he said his mom was taken to the hospital on . She was unable to get up and call for help and she was . She on herself and the doctor at the hospital said that based on her injuries, he believed she was on the floor for a long time. At the time of the incident, she was on the independent living side of the facility. Her contract indicated the facility would look in on her or call her every day. She had a pendant and was to push it every morning and if the facility did not hear from her by 10 a.m. or 11 a.m., they would check on her. On , she did not pick up her newspaper, did not fill out her medication diary, and was not at breakfast that morning.

During an interview with the director of nursing on at 1:30 p.m., she said there was no staff assigned to the independent portion of the facility, and the residents in that portion of the facility were not checked on throughout the day. The 3rd floor caregiver on the assisted side only assisted residents on the independent side with their medications. If the residents on the independent side needed assistance, they would use their pendant or pull cord in the apartment to call. If a resident did not have a pendant or was not able to reach the pull cord, they would yell out. An extra staff member was scheduled to float around the facility and be available to assist with tasks such as transporting residents. A security guard walked around the facility also.

During an interview with the administrator on at 1:45 p.m., he said the process for the residents who lived in the independent living portion of the facility was that the resident was to push a button in their apartment every morning to check in. The facility staffed a concierge every day who, if the resident did not check in by 10 a.m., would call the resident. The facility maintained a check-in log to reflect the process.

During an interview with the sales manager on at 2 p.m., she said she saw resident #3 on the morning of .

Review of the facility's check-in logs for and revealed that on at 10:24 a.m.,

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resident #3 was okay, and on at 10:03 a.m., resident #3 was out.

The record for resident #3 did not contain any documented evidence to indicate she was checked on or observed between at 10:24 a.m. and at 11:08 a.m. when she was found on her floor.

Review of hospital records revealed that resident #3 was admitted to the hospital on with a diagnoses of and Rhabdomyolysis. "Rhabdomyolysis is a condition in which damaged muscle breaks down rapidly." (Wikipedia.org).

A hospital history and physical report, dated , indicated that resident #3 had scattered on her skin and a to her region that was likely due to prolonged immobilization. In addition, the report indicated that clinically, it appeared that she was on the ground for an extended period of time.

On at 12:15 p.m., an exit conference was conducted with the administrator and he agreed with the findings.

2. Resident record review for resident #1 revealed an updated health assessment report 1823 dated that listed diagnosis of repair, , failure, and assistance was needed with self-administration of medications. The review revealed the Observation Medication Record (MOR), dated 2017, had staff initials circled on at 8 AM for all morning medications. The back page of MOR indicated that at 10 AM "resident out to church - medications wasted". The MOR dated 2017 had staff initials circled on for all medications. The back page of MOR indicated medications not given LOA (leave of absence). There were no written notations that indicated the resident was given the options to take the medications with her and take them later time to ensure the health care provider's orders were followed and desired outcome maintained.

Class II

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

Based on observations, record reviews, and interview, the facility failed to ensure the unlicensed staff who provided assistance with self-administration of medications followed the correct procedure for 1 of 2 medication passes (#1).

Findings:

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Observations of the assistance with self-administration of medication on at 10:30 AM noted that staff B, asked resident #1 if she was ready for her medications. She sanitized hands, reviewed the Medication Observations Record (MOR), and took medications from cart. She took the medications one by one and put them in a cup, added applesauce, signed the MOR, handed the cup to the resident and observed her take the medication. She did not read the label aloud to the resident. In an interview after the observation with staff, B said she knew what the medications were and told the residents what they were only if they asked.

Resident record review for resident #1 revealed an updated health assessment report 1823 dated that listed diagnosis of repair, failure, and assistance was needed with self-administration of medications.

In an interview with the administrator on at 3 PM, who said the staff needed to be re-trained.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on review of the facility's staffing schedules and interview, the facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern for a given time period.

Findings:

A request was made to review the facility's staffing schedule for 2017.

On at 2:30 pm, the director of nursing said the facility did not have the staffing schedule for 2017. Because the schedule was in the computer under the log in information for the previous director and she did not have access to the log in.

Class