STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963814	**06/20/2018**
NAME OF PROVIDER OR SUPPLIER **BV ASSISTED LIVING INC.**	STREET ADDRESS, CITY, STATE, ZIP CODE **2127 W. NEW HAVEN AVENUE** **WEST MELBOURNE, FL 32904**	

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

0000 - Initial Comments

A Complaint Investigation #2018005228 was conducted on , and in conjunction to the re-licensure survey. Buena Vida Assisted Living license #8693 had deficiencies found pertaining to the Complaint Investigation.

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

Based on observations, interviews and record review the facility retained 3 of 6 sampled residents (#6, #7 and #8) who exceeded assisted living facility continued residency and retained 1 of 6 residents (#13) whose needs the facility could not meet.

Findings:

During the facility entrance on at 9:30 AM, the administrator identified resident # 7 as having discharged from hospice services and was under "pathways".

The memory care unit was a separate/ building from multi-story assisted and independent living. One must walk across the parking lot to reach the memory care unit.

Observations during the tour of the memory care unit at 10 AM, noted resident #7 was in bed. Her bed was in the low position with a floor mat in front of the bed. She was . The Licensed Practical Nurse (LP) who assisted during the tour said the resident had been with hospice for 5 years, there was no decline, so she was discharged. Pathways she said was a service for the families. An advanced Registered Nurse (ARNP) came to review the resident's medications and made suggestions to the resident's primary care provider (PCP). The ARNP did not work for the facility or the PCP. The pathways do did not provide any personal care to the resident. The facility staff provide personal care and she needed total care with all her activities of daily living.

Observations during the medication pass on 11:40 AM, in the memory care unit resident #8 was in bed. She banged the wall, calling out for someone to come. Once inside her asked where you were. Why you are not here? She complained of pain on her right hand.
She ambulated with assistance and a walker to common area. Once sat down, she chewed on her clothes. The LPN who assisted during the tour said the resident needed total care with bathing and was at a stage where she chewed her clothes. Her son brought her some adult teething toys.

Continued observations noted resident #6 sat in the common area. She was alert with . Her

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legs were very . The LPN said the resident's healthcare provider instructed to leave the legs open to air, no compression hose or leg wraps as the resident took them off because of her cognition. She needed total care with bathing to ensure her legs were clean and the resident was unable to reach and do clean them well, besides she was resistive to bathing.

Resident record review for resident #7 revealed a health assessment report 1823, not dated, that listed diagnoses of , debility and . She was alert to self only and nursing services needed form St Francis Pathways. The report indicated she needed total care with bathing, dressing, and toileting.

Resident record review for resident #8 revealed a health assessment report 1823 dated that listed diagnoses of , with behaviors. According to report, she needed total care with bathing.

In a telephone interview on at 2 PM with staff D who said had worked at the facility since 2016 and was a caregiver in the memory care unit (MCU). She complained to the administrator about the fact that she could not continue to take care of the residents. There were 3 residents who would get up at night; she could not do the laundry, as she had to look after them. She said it had become too much work for her alone. She said when 3 residents were up at the same time and walking around the unit, she could not provide care for the other residents. When other residents needed her, she would have to take the residents who were up with her, while she helped the other residents. She could not leave the residents roaming around unattended. Most nights the residents slept. When they were up it became a problem for 1 person (staff) to care for them. She said just the previous month the facility started to schedule to 2 staff at night in the memory care unit.

Staffing for the week of 11/ - - (week mentioned in complaint) -there were 864 staffing hours. There were nurses from 6:45 AM through 9 PM and there was a nurse available on call during off hours.

Review of the 2017 staff schedule dated 11/1 2017 to for the memory care unit revealed that there was one (1) staff assigned to work the unit from 11 PM to 7 AM during the month of .

Resident record review for resident #13 revealed a health assessment report 1823 dated that listed diagnoses of 's gait imbalance, , and aphasia. Per report, he weighed 195 pounds and was 68 inches tall.

Facility notes indicated that on

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resident slipped and in dining his apartment, hit head, sustained laceration, sent to local emergency

at 8:20 PM, resident slipped in , needed 911 lift and assist. Wife requested a urinalysis.

11/6 wife reported resident experienced increased and agitation. Wife reported resident experiencing aggression and . Requested wife to report new behavior to primary care provider (PCP) and see if he could order medication to help. She wanted to transfer him to the memory care unit.

11/7 Daughter stated resident becoming more aggressive, the PCP gave him that was started medication and seemed to work. Health assessment requested.

11/7 Wife said 7.5 milligrams (mg) was not making a difference on the resident's behavior. Nurse explained that usually it takes a few doses to see results. Wife wants to increase dose she called PCP. Resident showered by private aid. Nurse told wife to inform aid that if behaviors escalate to activate pendant and staff will respond.

exit seeking, verbally aggressive, will not eat or let staff toilet him.

order received

able to transfer with assist of private aide

up all night, attempted to crawl out of bed, private aide spend most night keeping him from falling "PRN (as needed) given with god effect"

11/4 private aide said resident continues to be restless. "Without one on one observations resident would definitely been on the floor requiring left assist due to one staff 11-7". Private aide gave him lunch he did not eat.

Resident seen by the Advanced Registered Nurse Practitioner (ARNP), ordered 0.5 mg at bedtime and , 125 mg twice a day. Discontinue , C, and fish oil. Labs in 10 days.

Overnight private aide said resident was hard to toilet due to resident's inability to stand or help in any way. He woke up attempted to get out of bed. The private aid needed CNA (Certified Nursing Assistant) staff to help resident back to bed. Attempted to toilet resident before lunch, he was unable to bare weight. Very concerned about transfer capabilities.

Private aid said resident was in the night, emptied drawers, and threw clothing "PRN given by staff". Slept for 2 hours.

Unable to stand, ,

, had private aid with him. Private aid and CNA helped him back to bed.

Resident unable to stand, private aide and nurse lifted resident

Late entry for at around 7 PM he became combative and pushed the Christmas tree. "He already had PRN medication and was too early for something else". Private aide call wife, she sat with him until 8 PM when the other private aide came in

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12/1 Lift assist called. Resident slid to the floor
12/1 Resident transferred to a skilled nursing facility

In an interview with the administrator on . . . . . at 3PM who said the staff approached her about the difficulties of having one (1) staff in the memory care unit during the 11 PM to 7 AM shift. She spoke with the executive director and got approval to schedule 2 staff during the 11 to 7 AM shift in the memory care unit.

Record review for resident #6 revealed a resident health assessment form 1823 dated . . . . . . The health care provider noted she required total assistance with bathing which exceeded the Assisted Living Facility continued residency requirements.

On . . . . . at 3 PM, the administrator confirmed the findings.

Class III

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

Based on record review and interview the facility failed to ensure it provided care and services appropriate to the needs on 1 of 6 sampled residents (#13) and did not make sure that healthcare providers' orders were followed.

Findings:

Resident record review for resident #13 revealed a health assessment report 1823 dated . . . . that listed diagnoses of 's gait imbalance, , and aphasia. According to the report, he needed assistance with self-administration of medications. Continued review revealed a healthcare provider's order dated . . . . that indicated discontinue , ... 5 milligrams (mg) at bedtime and . . . 0.5 mg twice daily as needed for . . . . Healthcare provider's order dated indicated 0.5 mg twice daily as needed. Another order dated . . . indicated 0.5 mg at bedtime and . . . . . 125 mg twice daily. The resident experienced agitation, aggression and inability to sleep.

The . . . . 2017 Medication Observation Record (MOR) listed

. . . . . 15 mg at bedtime and indicated on . . . "#2".The legend on the last page of the MOR

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indicated that #2 meant resident refused. The medication was marked as given and , after the medication was discontinued on .

5 mg at 9 PM and was blank from to , and indicated "#5". The legend on the last page of the MOR indicated that #5 meant medication was not available.

, 125 mg twice a day at 8 AM and 5 PM and was blank on at 5 PM.

On at 3 PM, the administrator confirmed the findings.

Class III