AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968567	08/05/2016
NAME OF PROVIDER OR SUPPLIER **VICTORIA LANDING**	STREET ADDRESS, CITY, STATE, ZIP CODE **1279 HOUSTON ST** **MELBOURNE, FL 32937**	

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

0000 Initial Comments

Complaint investigation #2016005005 was conducted in conjunction with complaint #2016006752 on through . Victoria Landing, license # 1234, had deficiencies found at the time of the visit.

0030 Resident Care - Rights & Facility Procedures

Based on record review and interview the facility did not ensure an injury of unknown original was carefully investigated for 1 of 5 residents (4) sustained a hip .
Findings:
Health assessment report 1823 dated / listed diagnoses of , , and . Her status was described as moderate . She needed supervision with ambulation, eating and transferring; assistance with bathing, dressing, and toileting. She needed assistance with self- administration of medication. An x-ray result dated / Results shoulder unremarkable shoulder Hip acute left hip involving the left neck with impaction and displacement. Order dated / indicated send to ER 911 x ray left shoulder and hip pain and possible .
The facility notes documented:
/ / at 1600 resident was in bed today, not feeling well private aide present - fluids offered frequently - taking sips
/ at 0830 Private aides present - resident assisted out of bed to chair - taking sips of fluids. Son notified of poor appetite and .
/ at 1700 a to left shoulder and left elbow noted also complained of left leg pain with movement. No on left leg or anywhere else except left shoulder elbow range of motion done without pain.
/6 complained of pain to left hip also noted to left shoulder, order received for x- ray to left shoulder and hip. Resident complained of pain and possible Mobile-x to come in.
/ 4:30 PM x ray result received and reviewed by primary care provider (PCP) positive for left hip. Resident taken to hospital.
Primary care provider examination report dated /6 indicated she was being seen because of a change in condition. The resident was seen by the same healthcare provider on / . The hand writing extremely difficult to read. The note mention possible , had not eaten enough the last 2 days. She was unable to move limbs to full range of motion. Left hip x- ray ordered.
During an interview on at 11AM the administrator he stated the resident was not feeling well on Saturday. She had private care givers every day from 8a-12pm and 4p -8pm. Then the facility staff took over when the private caregivers were not there. None of the facility staff reported a that weekend. An e-mail was received on / at 5 PM from the facility administrator with the documentation of her investigation regarding the events that lead to the resident ' s hip. Review of the documentation

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received revealed 2 statements not dated or signed. The statements did not indicate the shifts the staff worked. There were no statements from everyone involved and more detailed information for each day. Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Victoria Landing
1279 Houston St
Melbourne, FL 32937

RE: CCR #2016005005

Dear Administrator:

This letter reports the findings of a state licensure complaint investigation survey that was conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call Lorraine Henry at -2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

Orlando Field Office
400 W. Robinson St., Suite S-309
Orlando, FL 32801
Phone:(407) 420-2502; Fax:(407) 245-0998
AHCA.MyFlorida.com