Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932401	A. BUILDING: _____ B. WING _____	10/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA RIO VISTA	1115 SE 6TH TERRACE FORT LAUDERDALE, FL 33316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments An unannounced Licensure complaint survey, #2019013287 was conducted on [redacted] at Villa RioVista. The facility had deficiencies at the time of the survey.	A 000		
A 030 SS=D	59A-36.007(6) FAC; 429.28(..) FS 429.27 Resident Care - Rights & Facility Procedures 59A-36.007 (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Program must be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to rule 59A-36.006, F.A.C. (b) In accordance with section 429.28, F.S., the facility must have a written grievance procedure for receiving and responding to resident complaints and a written procedure to allow residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The telephone number for lodging complaints against a facility or facility staff must be posted in full view in a common area accessible to all residents. The telephone numbers are: the Long-Term Care Ombudsman Program, 1(888)831-0404; [redacted], Rights Florida, 1(800)342-0823; the Agency Consumer Hotline 1(888)419-3456, and the statewide toll-free telephone number of the Florida Hotline, 1(800)96- [redacted] or 1(800)962-2873. The telephone numbers must be posted in close proximity to a telephone accessible by residents and the text must be a minimum of 14-point font.	A 030		

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A 030	Continued From page 1 (d) The facility must have a written statement of its house rules and procedures that must be included in the admission package provided pursuant to rule 59A-36.006, F.A.C. The rules and procedures must at a minimum address the facility's policies regarding: 1. Resident responsibilities; 2. and tobacco use; 3. Medication storage; 4. Resident elopement; 5. Reporting resident , neglect, and , ; 6. Administrative and housekeeping schedules and requirements; 7. control, sanitation, and universal precautions; and, 8. The requirements for coordinating the delivery of services to residents by third party providers. (e) Residents may not be required to perform any work in the facility without compensation. Residents may be required to clean their own sleeping areas or apartments if the facility rules or the facility contract includes such a requirement. If a resident is employed by the facility, the resident must be compensated in compliance with state and federal wage laws. (f) The facility must provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to section 429.28(1)(d), F.S. The facility must allow unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there must be, at a minimum, a readily accessible telephone on each floor of each building where residents reside. (g) In addition to the requirements of section 429.41(1)(k), F.S., the use of physical	A 030		

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A 030	Continued From page 2 by a facility on a resident must be reviewed by the resident's physician annually. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance, is not considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to pursue the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the	A 030		

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A 030	Continued From page 3 resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a room with his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Assistance with obtaining access to adequate and appropriate health care. For purposes of this paragraph, the term "adequate and appropriate health care" means the management of medications, assistance in making . , , ... for health care services, the provision of or arrangement of transportation to health care , , , and the performance of health care services in accordance with s. 429.255 which are consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , , the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for	A 030		

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A 030	Continued From page 4 a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. (2) The administrator of a facility shall ensure that a written notice of the rights, , and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. The notice must include the statewide toll-free telephone number and e-mail address of the State Long-Term Care Ombudsman Program and the telephone number of the local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and, if applicable, , Rights Florida, where complaints may be lodged. The notice must state that a complaint made to the Office of State Long-Term Care Ombudsman or a local long-term care ombudsman council, the names and identities of the residents involved in the complaint, and the identity of complainants are kept confidential pursuant to s. 400.0077 and that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right. The facility must ensure a resident's access to a telephone to call the State Long-Term Care Ombudsman	A 030		

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A 030	Continued From page 5 Program or local ombudsman council, the Elder Hotline operated by the Department of Children and Families, and , Rights Florida. 429.27 Property and personal affairs of residents.- (1)(a) A resident shall be given the option of using his or her own belongings, as space permits; choosing his or her roommate; and, whenever possible, unless the resident is adjudicated , or , under state law, managing his or her own affairs. (b) The admission of a resident to a facility and his or her presence therein shall not confer on the facility or its owner, administrator, employees, or representatives any authority to manage, use, or dispose of any property of the resident; nor shall such admission or presence confer on any of such persons any authority or responsibility for the personal affairs of the resident, except that which may be necessary for the safe management of the facility or for the safety of the resident. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to acknowledge a Resident's Power of Attorney (POA)'s verbal grievance. As evidence of the facility failure to notify the Power of Attorney (POA) regarding Resident #1's elopement that occurred in the facility and the safe return of the resident per the request of the POA after being only notified by the local police of the matter. The findings included: During an interview with Resident #1's POA on	A 030		

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A 030	Continued From page 6 . . . . . at approximately 2PM, it was revealed that he was made aware of Resident #1's elopement by local police on . . . . . at approximately 9 PM. He stated that the facility never contacted him regarding the elopement of Resident #1. He stated he immediately called the facility and informed the staff member on duty to notify him upon the return of Resident #1 to the facility and regarding his condition upon return. He wanted to make sure Resident #1 was ok and to determine if he needed to come to the facility that night for further attention of the matter or any other concerns that required immediate attention. He stated he never received any notification regarding the elopement; neither did the facility honor his request regarding notification upon Resident #1 return to the facility on the same day. Record review revealed the facility elopement policy undated stated in the event of an elopement the facility should conduct the following: Search the immediate area as soon as possible, inform the person in charge, inform the family member, inform the health provider and fill out an AHCA adverse incident report. An interview was conducted on at 11:01 AM with the Administrator and DON regarding the elopement of Resident #1. The Administrator stated the residents identified as an elopement risk resident should be checked on an hourly basis to ensure the overall wellbeing and safety of the resident. The Administrator stated that on . . . . . at approximately 9PM, he received a phone call from Staff A stating that Resident #1 was found by a nearby local Police Officer and was returned to the facility by the local Police Officer around 9PM.	A 030		

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A 030	Continued From page 7 The Administrator stated Staff A advised that Resident #1 was fine and had no concerns. At this time, the Administrator stated he made no further contact with Resident #1 POA for the rest of the night. The Administrator further stated the Staff member made no contact with the family member for the rest of the night. The DON stated he reported to the facility the following morning and assessed the resident and the resident appeared to be fine. After the assessment the DON, stated he called the family member and advised that Resident #1 was returned to the facility last night and was doing fine.	A 030		
A 032 SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons	A 032		

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A 032	Continued From page 8 that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S.	A 032		

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A 032	Continued From page 9 This Statute or Rule is not met as evidenced by: Based on interview, observation and record review, the facility failed to provide Supervision to at risk elopement residents, failed to provide and train staff with a detailed and specific elopement policy and failed to follow facility policy; specifically notifying 1 of 1 sampled resident in the return of a resident elopement. The findings included: Record review revealed the facility elopement policy undated stated in the event of an elopement the facility should conduct the following. Search the immediate area as soon as possible, inform the person in charge, inform the family member, inform the health provider and fill out an AHCA adverse incident report. An interview was conducted on . . . . . at 11:01 AM with the Administrator and DON regarding the elopement of Resident #1. The Administrator stated, the residents identified as an elopement risk resident should be checked on an hourly basis to ensure the overall wellbeing and safety of the resident. The Administrator stated that on at approximately 9PM, he received a phone call from Staff A stating that Resident #1 was found by a nearby local Police Officer and was returned to the facility by the local Police Officer around 9PM. The Administrator stated Staff A advised that Resident #1 was fine and had no concerns. At this time, the Administrator stated he made no further contact with Resident #1 POA for the rest of the night. The Administrator further stated, the Staff member made no contact with the family member for the rest of the night.	A 032		

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A 032	Continued From page 10 The DON stated he reported to the facility the following morning and assessed the resident and the resident appeared to be fine. After the assessment the DON, stated he called the family member and advised that Resident #1 was returned to the facility last night and was doing fine. The Administrator further stated camera footage revealed that Resident #1 had jump the 4-fence in the . . . of the facility around 7:00 PM and wasn't returned to the facility until 9:00 PM. The Administrator acknowledged that Staff A failed to conduct her hourly rounds to check on Resident #1 on this day and also failed to realize the resident had eloped. The Administrator stated that Staff A never realized Resident#1 was missing from the facility until he was brought by the local police officer. The facility policy failed to address specific duties and responsibilities for contacting law enforcement, the resident family and or guardian and the continued care in the event of an elopement. Record review of direct care staff files, confirmed all staff members had received training in Elopement Policy and Procedures; however, they were unable to demonstrate knowledge of the policy and procedures. During multiple confidential interviews with direct care staff on . . between the 10 AM and 2 PM, it was revealed all were unsure of what to do in the event of an elopement. All staff simply stated they would call law enforcement. No staff was able to reflect on the facility elopement policy. Further interviews with staff revealed that they had only one elopement drill at the facility and they were unclear of the facility policy.	A 032		

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A 032	Continued From page 11 In addition to the incident involving Resident #1, it was determined the facility had not conducted the required elopement drills. The facility failed to produce at a minimum two elopement drills per year with all staff. The facility produced one elopement drill with all staff dated , and another elopement drill dated . . . . . with three staff members listed. Class III	A 032		