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
	AL11910377	A. BUILDING: _____ B. WING _____	10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF DELRAY EAST	14555 SIMS ROAD DELRAY BEACH, FL 33484

(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, #2019012305 and #2019015950, was conducted on at Grand Villa of Delray East. The facility had deficiencies at the time of the survey.	A 000		
A 025 SS=D	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community.	A 025		

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A 025	Continued From page 1 (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility, for 1 of 3 sampled resident records reviewed (Resident # 1). As evidence of the facility failure to respond to Resident#1's care needs in a timely manner when he became wedged between the mattress and wall when the mattress flipped over. The findings included: A review of the facility's Incident Report Policy and Procedures dated ..... was conducted. The Incident Policy specifically addresses the following area: II. Completion of the Incident Report Form: E. Information noted On the form includes: 1. Date and time of the incident. 2. Location the incident occurred. 3. Name of the resident, visitor or staff member 4. Nature of the event.	A 025		

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A 025	Continued From page 2 5. Circumstances surrounding the incident, if known. 6. Names of any witnesses. 7. Date and time, the physician and legal respond representatives or next of kin were notified. 8. Physical assessment findings 9. Actions taken to address any injury. 10. Disposition of the injured person. 11. Signature and title of person completing the form. On [redacted] at 09:00 AM, an interview was conducted with the Administrator. She stated in [redacted], Resident # 1 was experiencing an episode of [redacted]. She stated he was trying to get out of bed and go to the bathroom. She stated somehow, he pulled on the sheet on the bed and the bed somehow flipped and caused him to become wedged between the wall and the mattress. She stated since he was not wearing his pendant, he was not able to contact the staff on duty. She stated the wife has a bedroom in the room with him and Resident # 1 told her to call 911 for help. She stated the Resident's wife did call the Paramedics and they were able to enter the facility without having staff open the door for them. She stated this incident took place on the overnight shift approximately 11:00 PM. On [redacted] at 10:00 AM, an interview was conducted with the Regional Director of Quality Assurance. She stated at the time the incident occurred; there were 2 direct care staff working in the general Assisted Living and 2 direct care staff working in the Memory Care Unit. She stated they acknowledged that more staffing is required on the overnight shift. A review of the medical chart for Resident # 1	A 025		

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A 025	Continued From page 3 was conducted. Resident # 1 was admitted into the facility . He suffers from the following diagnosis: [illegible] ( ), [illegible] ( ), [illegible] ( ), [illegible] ,and (Type II). He uses a walker to ambulate. He is alert and oriented x 3, and suffers from forgetfulness. Further review revealed the resident was using a on his bed for positioning which ultimately, contributed to the Resident #1's mattress flipping over causing the resident to become wedged on [illegible]. A review of the facility's Incident Report revealed the following sections were completed: The Resident's name, age, room #, date of incident, incident classification, time of incident, incident type, location of incident, incident details. The incident details are noted as the following: Resident had loose stools, pulled the sheet off of the bed, mattress slid up against the wall which resulted in resident being between bed and the wall. The medications were listed. Emergency Medical Services ( ) were called. Resident denied to he needed to go to the Emergency Room. No further information provided. A request was made for the investigative report regarding interviews and observations of the resident's room, no information was provided from the time period of 09:00 AM - 04:00 PM. Record review of the progress note dated [illegible] at 12:30 PM, revealed the following details of the incident that occurred on . The resident and wife were interviewed. The resident requested his wife to call 911. The resident complained of right [illegible]. Resident advised to rest on left side to allow his	A 025		

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A 025	Continued From page 4 right arm to rest. The physician was notified. The son was also notified. Memory Care Supervisor was the writer. On [redacted] at 12:30 PM, an interview was conducted with Resident #1's wife. She stated that Resident # 1 was stuck between the wall and the mattress on the bed. She stated he was left there for a very long time before he told her to call 911. She stated since the incident; he has nightmares at night about what occurred to him. She stated the staff never responded when she called. On [redacted] at 02:30 PM, an interview was conducted with the Director of Operations. She stated on [redacted], the incident was investigated. She stated that the call system is electronic and the time of the Resident's wife's call was logged at 10:43 AM. She stated the cameras on the front door revealed the Paramedics entered on their own at 11:14 PM. She confirmed that the Paramedics responded to the resident's room prior to the staff. She stated the staff went across the street to the Memory Care Unit to find out if the emergency personnel had gone there before responding to the resident's room. On [redacted] at 04:00 PM, an interview was conducted with the Administrator and the Regional Quality Analyst. They acknowledged the findings. Class III	A 025		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS.	A 079		

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A 079	Continued From page 5	A 079		

(a) Minimum staffing:
1. Facilities must maintain the following minimum staff hours per week:

Number of Residents, Day Care Participants, and Respite Care Residents	Staff Hours/Week
0-5	168
	212
16-25	253
26-35	294
36-45	335
46-55	375
56-65	416
66-75	457
76-85	498
86-95	539

For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week.
2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours.
3. At least one staff member who has access to facility and resident records in case of an emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility.
4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night.
5. A staff member who has completed courses in

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A 079	Continued From page 6 First Aid and . . . . . ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and . 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least . . . must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing	A 079		

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A 079	Continued From page 7	A 079		

requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C.
(c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives.
(d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met.
1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the

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A 079	Continued From page 8 increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the Assisted Living Facility (ALF) failed to assess the staffing ratios resulting in the potential for insufficient staffing to meet the needs of the residents residing at the facility. (Cross reference A 0025) The findings include: During an interview with the Administrator on at 9 AM, the incident regarding Resident #1 that occurred on at approximately 11 PM was discussed, including the lengthy	A 079		

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A 079	Continued From page 9	A 079		

timeframe the resident had to wait for staff assistance on around 11 PM. Ultimately, resulting in Resident #1's wife having to call Emergency Medical Services ( ) for Resident #1 due to lack of response by staff in a timely manner to assist the resident; when he had out of the bed and became stuck between the bed and the wall.

Further interview with the Administrator, at this time, she confirmed that more staffing is required on the overnight shift. She stated they have already hired 1 direct care staff for the overnight shift. She stated she is in the process of hiring 2 additional staff on the overnight shift this week. She was also unable to illustrate how the facility is meeting the staffing needs for residents based on concerns identified by residents and family members; while she is in the process of hiring new staff.

On , a review of the resident census and the staffing schedule was conducted. The review revealed that approximately a total of 157 residents in the entire facility on , the incident of Resident #1. There were approximately 26 residents residing in the secured Memory Care Unit on ; there were 2 direct care staff hired to work on the 10:00 PM - 06:00 AM shift that date. On , there were approximately 126 residents present in the general Assisted Living Facility; there were 2 direct care staff present on duty on the 10:00 PM - 06:00 AM.

On between 10:15 AM and 2 PM, confidential resident interviews were conducted, the following was revealed. The facility does not have enough people to assist residents. Residents have to wait a long time when

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A 079	Continued From page 10 requesting assistance. It was also revealed that they need to add more staff; high turnover of staff. A review of the grievance log revealed the following regarding Resident # 4. The Son reports on Saturday . . Son stated that the resident called for help at 7:47 PM, and they (Staff) responded at 09:30 PM. Was ready for bed and did not want to wait. No further follow-up completed by the facility regarding this staffing concern. A review of the Resident Council Minutes was conducted. The following complaints were noted: Weekend skeleton crew documented on . . . . . . On . . . . . at 04:00 PM, an interview was conducted with the Administrator and the Regional Quality Analyst. They acknowledged the findings. Class III	A 079		