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
	AL11967709	A. BUILDING: _____ B. WING _____	R 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA'S ALF 2 INC	16116 TAMPA STREET LUTZ, FL 33548

(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 A revisit survey to complaint investigation (# 20210140l4) was conducted at Villas ALF 2 Inc. on . Deficiencies were identified at the time of the survey.	{A 000}		
{A 025} SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. 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	{A 025}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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{A 025}	Continued From page 1 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. (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 observation, record review and interview, the facility failed to provide appropriate supervision and oversight to meet the needs of residents. Specifically, the facility left 5 (Residents #1, #2, #3, #4, and #5) of 5 medically and [illegible] residents with unqualified personnel in the facility placing all residents at imminent risk of harm and exacerbation of their health conditions due to missed medications, lack of provision of basic/activities of daily living (ADL) care and lack of supervision from or presence of a qualified staff member. Findings Included:	{A 025}		

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{A 025}	Continued From page 2 1. Upon entry of the facility on . . . . . at 7:00am, a male individual opened the door. He stated he was the mechanic, and he was there to fix things around the house. He further stated the staff would return at 11:00 a.m. Observation conducted on . . . . . beginning at 7:00am revealed there were no direct care staff in the facility and there were 5 residents in the facility. In an observation of Resident #2 on . . . . . at 7:45am-10:00 am he was looking around the facility for staff to get his medications and looking in the kitchen for coffee and in the refrigerator for something to eat. In an observation on . . . . . at 9:06am there was a knock on the facility door and an individual who identified himself as a mechanic opened the upper bolt lock on the front door with a key and Staff A entered the facility. In an interview with Staff A (Spanish speaking only) conducted on at 9:06am he said he was the one who worked in the facility and he gave the medications. He said there were no other employees. In an interview with Staff A on 11/23/2021 at 9:35am he said he works worked 24 hours a day but left the facility for an emergency. He said the mechanic was his friend. In an interview with Staff A on 11/23/2021 at 10:28am he said that he left the facility on an emergency at 6:00am. 2. In an observation of Resident #4 conducted on	{A 025}		

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{A 025}	Continued From page 3 . . . . . at 7:48am he was observed lying in a hospital bed on a mattress with no sheet on the mattress. Resident #4 was wearing only an adult brief and only a thin sheet for cover. There was a strong smell of . in the room. His bedroom window was open, and the air felt when entering his room. His . . . were yellow and covered in a thick film. He had food particles visible in his . . . and he was unshaven. His left arm was . with his left fist held up near his . . . . His bedside table was against the wall away from the bed and contained a red bowl with dry white rice and three pieces of some type of orange colored meat and a spoon. There was a plastic water bottle with amber colored liquid in the bottom of the bottle next to a pair of dirty gloves. His television screen was frozen on a picture of a remote. In an interview with Resident #4 conducted on . . . . at 7:48am, he said he needed to turn over but could not do it himself because his left arm did not work. He complained of being in , . , being extremely thirsty and . He said he needed to go to the hospital. He pointed to the plastic water bottle with amber liquid and said that he had . in the bottle yesterday to keep from wetting the bed and laying in it. Resident #4 asked the surveyor to shut his window and get him a blanket and some water. He said the leftover food was from dinner last night and it was not good, so he did not eat it. He asked surveyor to find his tv remote control so he could watch tv. In an interview with Resident #4 conducted on at 8:35am he stated he could not extend his left . out and again asked to go to the hospital because he was in . He said he was still very thirsty.	{A 025}		

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{A 025}	Continued From page 4 In an observation of Staff A on 11/23/2021 at 9:08am Staff A, at surveyor request, got , medication out of the facility's office for Resident #4 and held the pills in his , came into the kitchen to fill a cup with water from the coffee machine and walked into Resident #4's room. Staff A put the pills from his into the resident's without identifying what he was giving. Resident #4 told Staff A that he needed to go to the hospital. Staff A did not respond. In an interview with Resident #4 on at 9:18am he said he had still not been cleaned up or had care. In an observation of Staff, A on at 10:50am he was sitting on the couch in the common area looking at his cell phone. In an interview with Staff A on 11/23/2021 at 10:50am surveyor asked Staff A if he had done care for Resident #4, and he said he had not and got up to go into Resident #4's room. In an observation on at 11:07am Staff A was not found, and Resident #4 was naked in bed with no sheets or blankets covering him. There was a -soaked sheet and blanket on the floor of his room. There was a strong smell in the room. In an interview with Staff A on 11/23/2021 at 11:10am, Staff A said he had been looking for powder for Resident #4 so that is why the resident was naked in his bed. In an interview with Staff A on 11/23/2021 at 11:42am he said care for Resident #4 was done if surveyor needed to see Resident #4.	{A 025}		

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{A 025}	Continued From page 5 In an observation conducted on at 11:42am Resident #4 was lying in bed with a lit candle in front of television (the TV was stuck on a frame of a remote control) and the room smelled of . There was no cup near the resident for fluids. The bedside table was against the wall away from the bed. He was covered by a thin sheet and asking for a blanket because he was . In an interview with Resident #4 on at 11:42am he said his left does not extend, and that his left arm and had gotten worse in the past two months. He said he still did not feel well and needed to go to the hospital. In an attempted record review for Resident #4 conducted on there were no resident files in the facility. In an interview with Staff A on 11/23/2021 at 12:00pm, surveyor informed him that Resident #4 is asking to go to the hospital and is not feeling well. Staff A did not respond. An interview on at 2:19 p.m. with Advanced Registered Nurse Practitioner (ARNP). She stated Resident #4 was last seen by them on at that time he was able to sit at the edge of the bed. Photo Evidence Obtained. Class I	{A 025}		