

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2023
---	--	--	--

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 Relicensure, Complaint (#2023011269 and #2023011032) and Generator Monitoring survey was conducted on at Villa Rio Vista. The facility had a deficiency related to the Relicensure at the time of the survey.	A 000		
A 052	429.256() ; 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an _____ syringe that is prefilled with the proper dosage by a pharmacist and an _____ that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her _____ (d) Applying _____ medications.	A 052		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2023
---	--	--	--

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 052	Continued From page 1 (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a _____, including removing the cap of a _____, opening the unit dose of _____ solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the _____. (4) Assistance with self-administration of medication does not include: (a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a _____ of the body. (d) Administration of _____ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with _____, or _____ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/24/2023
NAME OF PROVIDER OR SUPPLIER VILLA RIO VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 2 reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be 18 years of age or older, trained to assist with self-administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2023
NAME OF PROVIDER OR SUPPLIER VILLA RIO VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 3 medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure that sanitary and control protocols were adhered to during the assistance with the self-administration of medications for 8 of 8 residents observed (Residents #9, #11, #12, #13, #14, #15, #16 and #17). And the facility staff	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/24/2023
NAME OF PROVIDER OR SUPPLIER VILLA RIO VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 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 052	Continued From page 4 failed to provide observation to ensure that residents swallowed the medication(s) provided. The findings included: During medication pass observations conducted on _____, this surveyor observed Director of Nursing (DON) Staff D assisting 8 residents with the self-administration of medications. During the medication pass observations, this surveyor observed DON Staff D begin the medication pass without washing or sanitizing her _____. DON Staff D was also observed placing cigarettes on the medication cart for 2 residents (Resident #9 and Resident #16) while performing the medication pass. DON Staff D was observed using her bare non-sanitized _____ to pick up the cigarettes and give them to Resident #9 and Resident #16. Specifically, the following was observed: During medication pass observation conducted on _____ at 12:17 PM, this surveyor observed DON Staff D open the medication cart in the dining room, gather the medication and scanned them (using the electronic medication system), open the packet, and place the medications in a small disposable paper cup, and give them to Resident #9 who swallowed them. DON Staff D then used her bare _____ to pick up 3 cigarettes she had placed on the medication cart and took them to the table where the resident went to sit and placed them on the table in front of her. DON Staff D did not wash or sanitize her _____ during the administration of the medications, or prior to handling Resident #9's cigarettes with her bare _____. During medication pass observation conducted on _____ at 12:20 PM, this surveyor	A 052			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2023
---	--	--	--

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 052	Continued From page 5 observed DON Staff D open the medication cart in the dining room, gathered the medication and scanned it, handed the pill packet to Resident #11 who walked away from the medication cart without being observed taking them. DON Staff D did not wash or sanitize her prior to handling the medications. During medication pass observation conducted on at 12:23 PM, this surveyor observed DON Staff D gather the medications from the medication cart, place them in a disposable paper cup, and handed the cup to Resident #12 who walked out of the dining room with the cup. It was not known if the resident took the medication or not. DON Staff D did not wash or sanitize her prior to handling the medication. During medication pass observation conducted on at 12:35 PM, this surveyor observed DON Staff D open the medication cart in the dining room, gather medication and scanned them, placed the medications in a disposable paper cup, give them to Resident #13 who walked away from the medication cart without being observed taking them. It was not known if the resident took the medication or not. DON Staff D did not wash or sanitize her prior to handling the medications. During medication pass observation conducted on at 12:36 PM, this surveyor observed DON Staff D open the medication cart in the dining room, gather medication and scanned them, placed the medications in a disposable paper cup, walked to the table where Resident #14 was sitting, announced the medication to her and then placed the medications inside the left side of Resident #14's	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2023
---	--	--	--

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 052	Continued From page 6 ... with her bare ... DON Staff D did not wash or sanitize her ... prior to handling the medications or after placing the medications inside Resident #14's . During medication pass observation conducted on ... at 12:38 PM, this surveyor observed DON Staff D open the medication cart in the dining room, gather medication and scanned them, placed the medications in a disposable paper cup, give them to Resident #15 who walked away from the medication cart without being observed taking them. It was not known if the resident took the medication or not. DON Staff D did not wash or sanitize her ... prior to handling the medications. During medication pass observation conducted on ... at 12:31 PM, this surveyor observed DON Staff D open the medication cart in the dining room, gather medication and scanned them, placed the medications in a disposable paper cup, poured water and gave the water and medication to Resident #16. DON Staff D then used her bare ... to pick up 3 cigarettes that she had placed on the medication cart and handed them to the resident. DON Staff D did not wash or sanitize her ... prior to handling the medications or cigarettes. During medication pass observation conducted on ... at 12:33 PM, this surveyor observed DON Staff D open the medication cart in the dining room, gather medication and scanned them, placed the medications in a disposable paper cup and give them to Resident #17 without observing to see if Resident #17 swallowed the medications. DON Staff D did not wash or sanitize her ... prior to handling the medications.	A 052		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2023
---	--	--	--

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 052	Continued From page 7 During an interview conducted with the Administrator and DON Staff D on _____ at 4:32 PM, they were informed that DON Staff D did not wash or sanitize her _____ during the entire observation of administration of medications to the 8 residents observed. DON Staff D acknowledged that she had not washed or sanitized her _____ while assisting with the self-administration of medications. Class III	A 052		