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
	AL11910336	A. BUILDING: _____ B. WING _____	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ORMOND BEACH	535 NORTH NOVA ROAD ORMOND BEACH, FL 32174

(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 relicensure survey with complaint investigation (complaints# 2023010579, 2023009517, 2023003953 and 2024003423) was conducted at Grand Villa of Ormond Beach from [redacted] to [redacted]. Deficient practice was identified during the survey.	A 000		
A 028 SS=F	59A-36.007(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities must offer supervision of or assistance with activities of daily living as needed by each resident. Residents should be encouraged to be as independent as possible in performing activities of daily living. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide timely assistance with activities of daily living (ADLs) for 1 of 10 sampled residents. The findings include: During an interview with Resident 12's representative on [redacted] at 10:55 am, she stated Resident 12's [redacted] were often soiled with feces when she visits. She was not sure Resident 12 was being changed frequently enough. The representative described the resident as being resistive to care, explaining to get her to cooperate, you just have to say over and over, "We gotta do this." An observation of Resident 12 was conducted on [redacted] at 11:25 am in the memory care unit (MCU) dining room. She was seated at a table and was touching and holding [redacted] with other	A 028		

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A 028	Continued From page 1 residents. While she appeared clean and dressed appropriately, there was a brown substance under and around all edges of her . Lunch service had commenced and the resident was observed drinking juice from the cup in front of her. Employee D, Medication Technician (MT), was interviewed on at 11:40 am about Resident 12's nails. She explained Resident 12's behaviors as digging in her feces and placing her in her undergarment when soiled. She explained the overnight staff were tasked getting this resident up in the morning, but she often observed Resident 12's soiled upon arrival, so it on the morning shift to do it. When attempting to clean her , Resident 12 screamed we were "trying to kill her". Employee D confirmed the resident's nails had not yet been cleaned today, and said she would take Resident 12 to do it after lunch. She was asked about the risk of Resident 12 eating with soiled and getting ill from contamination. Employee D agreed and said she would do it now. In an interview with Resident 12 at this time, she was asked what about her . Resident 12 responded immediately, "I was digging in the turds." Photographic evidence obtained. Resident 12 and Employee D returned to the dining minutes later and the resident's and no more brown substance was observed on the . Employee D reported the resident screamed at her during the procedure, but said family knows that happens and have seen it her do that. Employee E, MT, was interviewed at 11:20 am on . She explained a lot of residents on the MCU refuse care, and there are a lot of	A 028		

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A 028	Continued From page 2 combative behaviors. She tried to redirect the residents and tried up to two more times when residents refuse. Resident 12 dugs in her undergarment and scratched herself. She often refused care on a daily basis. If the overnight shift didn't get Resident 12 up before the morning shift gots in, it took two staff to get her up. Employee E explained it took two people to do nail care and dig out the feces, especially if she refused. Employee E has told the Memory Care Director (MCD). An interview was conducted with the MCD at 1:13 pm on . She confirmed Resident 12 had been engaging in digging lately. This behavior was new within the last couple months but she was doing it more. The behavior occured mostly at night. Between Hospice and the facility staff, she received assistance with 4 showers per week. She explained morning staff who got Resident 12 up should be cleaning her nails. It took multiple staff to do it, unfortunately, but they should be cleaned. On occasion, Resident 12 had been seen digging in her in common areas, which was an indicator she had defecated. In those cases, the MCD sent Resident 12 to her room with staff to be cleaned up. When shown the photographic evidence of Resident 12's nails from the day prior and advised staff planned to clean her after lunch, she confirmed it should have been done before the meal. The MCD confirmed the soiled state of Resident 12's , stating they should not be in that condition. Class III	A 028		
A 036 SS=F	59A-36.007(10) PROCEDURES CONTROL	A 036		

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A 036	Continued From page 3 (10) CONTROL PROCEDURES. Facilities must provide services in a manner that reduces the risk of transmission of (a) The facility must implement a hygiene program before and after the provision of personal services to residents whenever there is an expectation of possible exposure to materials or hygiene may include the use of -based rubs, handwash, or handwashing with soap and water. (b) Standard precautions must be used when there is an exposure to transmissible agents in , nonintact skin, and mucuous during the provision of personal services. Standard precautions include: hygiene, and dependent upon the exposure, use of gloves, gown, mask, protection, or a shield. (c) The facility must clean and reusable medical equipment and communal assistive devices that have been designed for use by multiple residents before and after each use according to the manufacturer's recommendations. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to practice control standards when passing beverages during meal service. This had potential to affect all residents of the memory care unit of the facility. The findings include: During lunch observation in the Memory Care Unit (MCU) dining room at 11:30 am on , Employee D, Medication Technician (MT), was	A 036		

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A 036	Continued From page 4 passing beverages to the residents. There were approximately 20 residents in the dining room, all seated at tables. The drinking glasses were nestled standing in a deep commercial dishwasher rack and filled before being distributed. Photographic evidence obtained. The drinking glasses were shorter than the of the rack, and were placed right side up instead of upside down, so Employee D had to reach in and retrieve the glasses by the drinking edge (where the residents would have placed their to drink) instead of the bottom of the cup that did not have contact. Using her bare , Employee D retrieved two glasses at a time (one in each) by the rim, resulting in all 5 contacting the drinking surface of the cups. Employee D passed drinks two at a time to 3 different tables (total of 6 glasses) with her bare . Lunch on the memory care unit was observed again on at 11:18 am. Employee H, MT, was passing out the drinks to the residents using the same retrieval method with bare . She was observed to pass glasses by the rim and with bare to 4 of the tables. An interview was conducted with Memory Care Director (MCD) at 1:13 pm on . When asked about her expectation for beverage service, she stated she believed staff should be wearing gloves. The MCD was advised of the bare contact with the drinking surfaces of resident glasses over the two day period. She said, "That's a good way to spread germs. That is not the expectation." Class III	A 036		