STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910377	12/17/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Grand Villa Of Delray East	14555 Sims Road Delray Beach, FL 33484	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G

Specific Tag Findings:

0000-Initial Comments
CCR#2013012888

A complaint inspection was conducted from to . The Grand Villa of Delray East assisted living facility was not in compliance during this complaint inspection.

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, record review and interview, the facility failed to provide supervision to 3 out of 5 sampled residents (Resident #s 1, 2 and 3) who were diagnosed with .

The findings are:

a) In an interview with the Director of Nursing (DON) on at 9:50am, she stated that Resident #1 was determined to have been missing from the facility on at approximately 9:00pm. She stated that due to the resident's condition, he was placed in the facility's memory care unit (MCU). She stated at this time that on at around 11:00pm, the law enforcement staff found Resident #1 with his body floating inside the western-most lake of the facility property.

In an interview with the Administrator on at 10:25am, she stated that on at around 8:00pm, Caregiver #1 assisted Resident #1 to bed in his (#166); Caregiver #1 then went to assist Resident #4 to bed in her (# which is located next to #166. She stated at this time that on at around 9:00pm, the supervising MCU nurse realized that Resident #1 was not in his . The supervising MCU nurse mobilized an immediate search within the MCU of the facility, which upon not locating the resident there, it turned into a facility-wide search. She stated at this time that upon the supervising MCU nurse not being able to locate Resident #1 in the facility on at around 9:30pm, the supervising MCU nurse notified her and then they contacted the local authorities to help find the resident. She stated at this time that on at around 11:00pm, the law enforcement staff found the lifeless body of Resident #1 in the western-most lake of the facility property.

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Review of Resident #1's record indicated that he was admitted to the facility on [redacted] with diagnoses including [redacted]. Review of the resident's health assessment dated on [redacted] indicated that the resident needed supervision with ambulation (with "redirection" noted) and transferring (without any comments noted) and he also needed assistance with self-administration of medication. Review of the resident's facility-developed memory support care-level assessment dated on [redacted] indicated that he did not need assistance with ambulation or transfers. Further review of the care-level assessment form revealed it had not be signed and dated by the required parties (the responsible party, the community representative and the Executive Director); the designated signature area for each party was left blank.

In an interview with the MCU staff nurse on [redacted] at 12:05pm, she stated that Resident #1 would regularly walk around the MCU independently and without an assistive device, and he would rarely use his wheelchair to get around.

In an interview with the supervising MCU nurse on [redacted] at 3:30pm, he stated that he continually saw Resident #1 walking independently, without supervision or an assistive device, all around the MCU and that on [redacted] at 7:30pm, the resident was walking around the MCU. He stated at this time that Resident #1 was well aware that if he holds any of the 4 MCU door bars for over 10 seconds, it will unlock and open. He stated at this time that the exit door next to the MCU nursing station would sometimes not buzz/alarm when forced open and would stay deactivated for some time and that resident #1 would regularly open this and other coded entry doors in the MCU, without entering any codes or alarms going off. He stated at this time that this would happen every day and that there was no care plan developed in order to mitigate this behavior for Resident #1. He stated at this time that Caregiver #1 reported to him on [redacted] at around 8:00pm, that she assisted Resident #1 into his bed. He further stated at around 8:15pm, Caregiver #1 requested his assistance to place Resident #2 in his bed, who was in the same [redacted] Resident #1. He stated at this time that although he did not look at Resident #1's side of the dimly lighted [redacted] that time; Caregiver #1 confirmed to him that Resident #1 was in his bed when they assisted Resident #2 into his bed at that time. He stated at this time that on [redacted] at around 9:00pm, he performed rounds in the MCU and realized that Resident #1 was not in his bed and he notified the 3 caregivers in the MCU to begin a search for Resident #1 within the MCU. He stated at this time that him and his MCU staff looked all around in the MCU for Resident #1 and could not find him, and that he did not hear any door alarms go off during the evening of [redacted] He stated at this time that on [redacted] at around 10:00pm, they called 911 to aid in the search of the resident, to which law enforcement staff responded to the facility and found the resident ' s body on [redacted] around 11:00pm.

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In an interview with the supervising MCU nurse on , at 4:15pm, he stated that he verbally notified his former MCU supervisor several times about the doors that would not alarm or reset in the MCU during the past month and that he relied on her to report this to administration for proper repair. He stated that up to , he had no reason to believe that the MCU security doors were repaired.

In an interview with Caregiver #1 on , at 4:00pm, she stated that Resident #1 used to always walk around the MCU independently, without any assistive device and that on , shortly before 8:00pm, he was indeed walking around the unit and she assisted him to his bed. She stated at this time that shortly after 8:00pm, she helped Resident #1's , Resident #2 into his bed and she remembers that Resident #1 was in his own bed at that time. She stated at this time that a short time thereafter, she was emptying the residents ' garbage around the MCU activity area and she saw Resident # 1 and 2 walking together in the memory care unit (MCU) hallway and then saw them go into their , and that this was not uncommon because both of these residents were avid walkers and would walk around the whole MCU. She stated at this time that around 8:45pm, she went on break outside of the MCU and into the main facility employee break . She stated at this time that shortly thereafter, the supervising MCU nurse called her to notify her that resident #1 was not in his to assist him with a search of resident #1 in the MCU. She stated at this time that resident #1 was not found until after the law enforcement staff arrived to the facility and found resident #1's body in the lake.

In an interview with the Administrator on , at 12:20pm, she stated that based on the facility's investigation on the events surrounding Resident #1's elopement on , she could determine with moderate level of certainty that the resident left the locked MCU around 8:00pm, most likely following an employee out of the coded south door, which leads to the general facility hallway.

b) In an observation on , from 3:00pm to 3:15pm in the MCU, Resident #2 was walking independently with a rolling walker, in and out of the MCU dining , the hallway and back into the dining he then went inside the MCU kitchen. It was observed at this time, that no persons or staff members were present in aforementioned areas to supervise or assist Resident #2.

In an attempt to interview Resident #2 on , at 3:10pm, it was not possible because the resident presented to be alert and considerably . In an observation on , at 3:15pm, the Activity Director was notified that Resident #2 was inside the MCU kitchen and she immediately went to his side to assist him outside the kitchen and into the MCU activity area, where other residents and staff members were present.

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In an interview with the Activity Director on at 3:15, she stated that Resident #2 is one of a few residents in the MCU which likes to walk all over the place, wanders and although he does not actively seek exit from the MCU, he would occasionally attempt to walk outside the MCU if a door was opened. She stated at this time that Resident #3 is another current resident who walks around independently. She stated Resident #1 used to also walk independently throughout the MCU and he would exhibit wandering and exit-seeking behaviors and Resident #1 would set off door alarms on a daily basis.

Review of Resident #2's record indicated that he was admitted to the facility on with diagnoses including and Review of his health assessment dated on indicated that the resident needed assistance with ambulation (with "assistive device" noted) and transferring (with "for safety" noted) and needed medication administration. Review of the resident's facility-developed memory support care-level assessment Further review of the care-level assessment form revealed it had not be signed and dated by all 3 required parties (the responsible party, the community representative and the Executive Director); the designated signature area for the responsible party and the Executive Director was left blank.

c) Review of the facility elopement drills dated on and indicated that the supervising MCU nurse participated in this training on and caregivers #1, 2 and 3 did not participate in any of these elopement drills or trainings.

In an interview with the Administrator on at 9:45am, she stated that she was aware that all the 4 ingress/egress doors in the MCU do unlock/open after holding their bars for an extended period to comply with fire codes and that they make a loud buzzing/alarming noise when opened. She stated at this time that she was not aware that any of these doors were not functioning correctly.

In an interview with Caregiver #2 on at 10:30am, she stated that she knew Resident #1 well, she was working in the MCU on and she last saw the resident in his at approximately 8:00pm. She stated at this time that she did not hear any of the door alarms go off on the evening of but she was aware that the ingress/egress door located next to the MCU nursing station had been for about one month because it would sometimes not buzz or alarm when opened. She stated that she has mentioned this to her supervisor, the former MCU supervisor, but nothing had been done about it because the door was not fixed.

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In an interview with the Administrator on at 12:50pm, she stated that the facility has not yet examined the individual resident behaviors in the MCU to reduce the risk of elopements. She also stated at this time that the security door contractor was called on to review the door security systems in the MCU so they can adjust the timing parameters in the doors, because the doors used to stay unlocked/open for a few more seconds after coded ingress/egress.

In an interview with the DON and the Administrator on at 1:30pm, they both stated that they have not been informed or were aware of any of the MCU security doors to have been during the past 3 months.

In an interview with the Administrator on at 10:05am, she stated that the facility's nurse performs a move-in/care-level assessment on every resident in the facility and every direct care staff member uses this assessment as the basis of the individual care extended to each resident. In an interview with the DON on at 12:00pm, she confirmed that the MCU and general facility residents receive an initial care-level assessment that is used as a care plan by the direct care staff.

d) In an observation on at 11:00am, Resident #3 was walking independently, without an assistive device in the MCU main hallway; he then went towards the MCU lobby's front door and attempted to open the door by pressing on the bar for approximately 5 seconds and the door sounded a barely-audible alarm to which the MCU staff nurse responded to and redirected the resident to the activity area.

Review of Resident #3's record indicated that he was admitted to the facility on with diagnoses including and Review of his health assessment dated on indicated that the resident needed assistance with ambulation (with "unaware of unsafe areas" noted) and supervision with transferring (with no comments noted) and needed assistance with self-administration of medication. Review of the resident's move-in assessment dated on indicated that he was not oriented to his surroundings or daily routine, and it was noted that he is a wanderer.

In an interview with former MCU supervisor on at 12:25pm, she stated that she did not experience any with the MCU security doors, nor was she notified of any of the MCU doors by the staff. She stated at this time that she understood every MCU resident to be an elopement risk and the facility did not perform any specific resident elopement assessments.

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The facility failure to provide supervision appropriate to 3 resident's that suffered from directly affected the safety and well being of the residents (Resident #1, #2 and #3). The facility also failed to adequately assess each resident upon admission to ensure appropriate supervision.

Class II

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Grand Villa Of Delray East
14555 Sims Road
Delray Beach, FL 33484

Dear Administrator:

This letter reports the findings of a complaint inspection survey (CCR# 2013012888) conducted on , 2013 to , 2013 , by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this hand delivered report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G

Directed Corrective Actions:

1) The Assisted Living Facility is required to increase staffing in the Memory Care Unit by 2 additional qualified staff persons on each shift and maintain written work schedule for review.
2) The Assisted Living Facility is required to implement an hourly observation log of all residents.
3) The Assisted Living Facility is required to within 48 hours, a Registered Nurse must conduct a facility-wide elopement risk assessment of all the residents in the facility and refer any resident to their Health Care Provider if their health.
4) The Assisted Living Facility is required to conduct elopement drills on all shifts within 10 days of the date of this letter and quarterly thereafter.
5) The Assisted Living Facility is required to test all exit doors daily and maintain log for review.
6) The Assisted Living Facility is required to conduct monitoring of the adjacent facility grounds every 4 hours and maintain a log for review.

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call Catherine Anne Avery, Survey and Certification

Grand Villa Of Delray East
, 2014
Support Branch, at 850-412-4505 or Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor at 561-381-5846.

Sincerely,

T. Wedges Phoenix, Supervisor

for Arlene Mayo-Davis
Field Office Manager

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