STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910377	01/14/2014
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 - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G

Specific Tag Findings:

0000-Initial Comments

A unannounced complaint inspection survey (CCR#2014000283) was conducted from to . The Grand Villa of Delray East assisted living facility was not in compliance during this complaint inspection.

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, record review and interview, the facility failed to provide a safe environment to the facility's memory care unit (MCU) residents due to having a door in the MCU and the facility failed to extend adequate and appropriate health care to 6 out of 11 sampled residents assessed to be elopement risks (Resident #s 1, 2, 3, 4, 5 and 6) by not referring them to their individual physicians and not monitoring them adequately.

The findings are:

Review of Resident #6's record indicated that the resident's elopement risk assessment dated on and performed by the facility's registered nurse, indicated that the resident was an elopement risk and needed increased staff monitoring because he was with .

In an interview with the direct care nurse on at 1:35pm, she stated that on Resident #6's wife took the resident out of the facility without signing him out, and this resident was discovered to be missing for more than 15 minutes. She stated at this time that caregiver A found out that the resident was missing as caregiver A performed her 2-hour resident checks and caregiver A informed her immediately of the missing resident. She stated at this time that she proceeded to call the resident on his cell phone and his wife answered, and the resident's wife told her that everything was okay and she said she was testing the facility to ensure adequate missing-resident response.

In an interview with the direct care nurse on at 1:45pm, she stated that she used to work in the MCU a few months ago and she did not know of the MCU security doors to be . She stated at this time that she knew that the MCU door alarms were not overly loud and they could not be heard from one end of

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the MCU to the other if activated.

In an interview with caregiver A on at 9:45am, she stated that she saw Resident #6 on at approximately 2:15pm in the main lobby. Then, at around 2:45pm on the same day, she did not see him around, so she started looking for him in the main area of the facility. She stated at this time that she looked for him in his in the and in the activity but she did not find him. She stated at this time that she asked the receptionist if the resident had left and they confirmed that the resident was not signed out from the facility in the log book located in the main lobby. She stated at this time that she notified the direct care nurse and she attempted to call the resident on his personal cell phone but no one answered at first. She stated at this time that the staff searched the whole facility but they did not find the resident and then his wife answered the resident ' s cell phone and she said the resident was fine, that they went out for a little while and they will return to the facility in short time. She stated at this time that the resident returned to the facility with his wife later on the same day without incident.

Review of the incident report dated on indicated that Resident #6 went missing from the main facility at 2:51pm and that the resident ' s wife contacted the facility at 4:00pm on the same day to notify the facility that the resident was okay. Further review of the incident report indicated that the resident ' s wife was told after the incident, to sign the resident out every time they go out of the facility and the resident remains on the established 2-hour monitoring check.

In an interview with the memory care unit (MCU) nurse on at 3:00pm, she stated that Resident #12 is the only current resident in the MCU who has wandering and exit-seeking behaviors.

In an interview with the Administrator on at 3:55pm, she stated that the 10 main facility residents identified by the registered nurse to be an elopement risk in 2013 were:

1. Resident #1: assessed to be an elopement risk, to be placed in the MCU or to be issued a discharge notice.

2. Resident #2: assessed to be an elopement risk and to be placed in the MCU.

3. Resident #3: assessed to be an elopement risk, to be placed in the MCU or to be issued a discharge notice.

4. Resident #4: assessed to be an elopement risk, to be placed in the MCU or to be issued a discharge notice.

5. Resident #5: assessed to be an elopement risk, to be placed in the MCU or to be issued a

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discharge notice.

6. Resident #6: assessed to be an elopement risk with increased monitoring.

7. Resident #7: assessed to be an elopement risk with increased monitoring.

8. Resident #8: assessed to be an elopement risk with increased monitoring.

9. Resident #9: assessed to be an elopement risk with increased monitoring.

10. Resident #10: assessed to be an elopement risk with increased monitoring.

The Administrator stated on _ _ _ _ at 4:00pm, that Resident #2 was identified to be an elopement risk on like the other at-risk residents, and the resident ' s family was contacted to inform them that the resident could not remain in the main facility side and needed to be transferred to the exit-controlled MCU. She stated at this time that the only action the facility has made with the identified at-risk residents was only to contact their family members to inform them of the elopement risk results and has not made contact with their physicians; nor made efforts to modify the residents' exit-seeking behaviors or actually move the residents to the MCU. She stated at this time that the facility's regional manager and her made the decision to not immediately issue any discharge notices or initiate steps to move any of the identified at-risk residents, which went against the recommendations of their risk assessments. She stated at this time that the facility ' s intent was to further observe these at-risk residents, for an undetermined period of time, by means of maintaining an accurate 2-hour check log on all the at-risk main facility residents and re-assess the at-risk residents sometime in the future. She stated at this time that upon review of the resident log records, the main facility at-risk residents have not been 100% monitored since the 2-hour check logs have missing monitoring data in them, and the facility has not re-assessed any of them or contacted any of their physicians regarding their elopement risk.

Review of the resident check logs dated from _ _ _ _ to indicated that the staff did not record the 2-hour checks accurately for every resident in the main facility assessed to be an elopement risk, including: Resident #6 was not monitored on _ _ _ _ from 6am to 2pm, on from 7am to 3pm and on _ _ _ _ from 7am to 9pm, Resident #5 was not monitored on _ _ _ _ at 2pm and on from 3pmto 9pm, Resident #10 was not monitored on _ _ at 2pm and on _ _ _ _ from 3pm to 9pm, Resident #8 was not monitored on _ _ at 6am and on _ _ _ _ from 3pm to 9pm and Resident #9 was not monitored on _ _ from 7am to 3pm, on , and _ _ from 7am to 1pm and on _ _ _ from 3pm to 9pm.

In an interview with the direct care nurse on at 4:35pm, she stated that there was no documentation that the physicians of any of the residents with an increased elopement risk were contacted to discuss their

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status.

Review of the elopement risk residents' records did not indicate that their physicians were contacted by the facility to notify them of their increased elopement risk status, including the following:

1. Review of Resident #2's record indicated that she was admitted to the facility on with diagnoses including and Review of the resident ' s health assessment dated on indicated that she was independent with all of her activities of daily living, that she needed skilled nursing services and was a risk. Review of the resident ' s elopement risk assessment dated on indicated that the resident was an elopement risk and needed to be transferred to the MCU. Review of the resident ' s progress notes did not indicate any communication with her physician regarding the outcome of her elopement assessment or any behavior modification strategies being implemented.

2. Review of Resident #4 ' s record indicated that she was admitted to the facility on with diagnoses including ' s left eye and Review of the resident ' s health assessment dated on indicated that she was independent with all of her activities of daily living, with exception to bathing which she needed supervision with, she needed to walk with a walker, had precautions and was Review of the resident ' s elopement risk assessment dated on indicated that the resident was an elopement risk and needed to be transferred to the MCU or issue a discharge notice from the facility. Review of the resident ' s progress notes did not indicate any communication with her physician regarding the outcome of her elopement assessment or any behavior modification strategies being implemented.

3. Review of Resident #3 ' s record indicated that she was admitted to the facility on with diagnoses including and Spinal Review of the resident ' s health assessment dated on indicated that she needed assistance with all of her activities of daily living, except with eating which she was independent, that she needed prevention, she had gait instability and had memory loss. Review of the resident ' s elopement risk assessment dated on indicated that the resident needed to be transferred to the MCU or issue a discharge notice from the facility. Review of the resident ' s progress notes did not indicate any communication with her physician regarding the outcome of her elopement assessment or any behavior modification strategies being implemented.

4. Review of Resident #1 ' s record indicated that she was admitted to the facility on with diagnoses including Chronic and Review of the resident ' s health assessment dated on indicated that she needed assistance with all of her

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activities of daily living, except with ambulation and eating which she was independent, that she needed safety precaution, she was unsteady and forgetful. Review of the resident ' s elopement risk assessment dated on . indicated that the resident was an elopement risk. Review of the resident ' s progress notes did not indicate any communication with her physician regarding the outcome of her elopement assessment.

5. Review of Resident #5 ' s record indicated that he was admitted to the facility on . with diagnoses including . Review of the resident ' s health assessment dated on . indicated that he needed assistance with all of his activities of daily living, except with eating which he was independent, that he needed . prevention and he had gait instability. Review of the resident ' s elopement risk assessment dated on . indicated that the resident was wandering, needed to be transferred to the MCU or issue a discharge notice from the facility. Review of the resident ' s progress notes did not indicate any communication with his physician regarding the outcome of his elopement risk assessment.

6. In an observation on . at 8:30am, Resident #9 was walking independently from the main lobby to the front entrance courtyard of the facility. In an interview with the resident at this time, she stated that she has been living in the facility for approximately 10 weeks and that she likes it living there. She stated at this time that she is independent and knows how to get around the facility. The resident presented to be alert and minimally . at this time. Review of the resident ' s elopement risk assessment dated on . indicated that the resident was at risk for elopement, she required increased monitoring and did not need to be transferred to the MCU.

7. Review of Resident #12 ' s record indicated that he was admitted to the facility on . with diagnoses including . ' s . 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 his 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. Review of the resident ' s elopement risk assessment dated on . indicated that he was an elopement " high " risk with a total score of 32, with any score greater than 10 indicated as a risk. Review of the resident ' s progress notes did not indicate any communication with his physician regarding the outcome of his elopement assessment or any behavior modification strategies being implemented.

8. In an observation on . at 5:00am, the MCU doorway leading to the main facility was not locked or alarmed. In an observation on . at 10:25am, Resident #12 was walking independently in the

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MCU hallways with visual supervision by the direct care staff. The surveyor attempted to interview the resident at this time but it was not possible because he presented to be considerably _____.

In an observation on _____ at 5:00am, the MCU doorway leading to the main facility, it was not locked or alarmed.

In an interview with the supervising MCU nurse on _____ at 5:10am, she stated that the MCU security coded doorway leading to the main facility was supposed to be working properly, but it is not because it was unlocked since the beginning of her shift at 11:00pm last night. In an observation on _____ at 5:10am, the MCU doorway leading to the main facility was not locked or alarmed. In further observations at this time, it was also noted that the front door of the main facility, which is approximately 100 yards from the MCU security coded door, was unlocked and could be opened by pressing of the door bars without any alarms sounding and reentry from the outside was not possible because the door was locked after it closed.

In an interview with the supervising MCU nurse on _____ at 5:15am, she stated that the main facility front door is unlocked and not alarmed, and anyone can leave but the door remains locked from the outside. She also stated at this time that the MCU to main facility doorway was _____ by being unlocked today and that this also occurred approximately a month ago.

In an interview with the supervising MCU nurse on _____ at 5:55am, she stated that she attempted to reset the MCU security door a few times that night, but it did not reset, and that once she contacted the Administrator by telephone, she walked through another resetting method which made the MCU door lock and properly function again.

In an interview with the Administrator on _____ at 10:35am, she stated that the missing spots on the at-risk resident log were there because the direct care staff did not record that some residents left the facility with family members and/or they may have forgot to record their observations altogether. She stated at this time that besides the MCU-main facility door _____ today, it was not locking a couple of weeks ago and the door was reset with the code in order to function properly again.

Class II

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AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Grand Villa of Delray East
Administrator
14555 Sims Road
Delray Beach, Florida 33484

Dear Administrator,

This letter reports the current findings of a complaint inspection (CCR# 2014000283) initiated on , 2014 by a representative of the Agency for Health Care Administration. Attached is the provider's copy of the State (3020) Form, which indicates there were deficiencies noted during this inspection.

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

A30 Resident Rights to a Safe Environment and Appropriate Health Care- Class II

The Assisted Living Facility failed to provide a safe environment to the facility's memory care unit (MCU) residents by having a door in the MCU and the facility failed to extend adequate and appropriate health care to its residents assessed to having an elopement risk by not referring them to their individual physicians and not monitoring them adequately.

You are hereby directed to provide the following corrective actions effective immediately:

1. Residents identified to have exit-seeking behaviors or having an elopement risk by determination of the facility's registered nurse must be further examined by a physician/physician extender with completion of a current AHCA 1823 health assessment form.

2. Facility must perform systematic, continual and as-needed re-assessments of any residents exhibiting at-risk behaviors consistent with exit-seeking behaviors and/or having an elopement risk, by a registered nurse.

3. Continue monitoring all the facility residents to ensure their safety and wellbeing is maintained and dedicate one staff member to observe the MCU doorways at all times, 24 hours per day to ensure no resident leaves the MCU without proper supervision.

4. Ensure that all the four (4) MCU security coded doorways are in proper working condition by providing written confirmations by each of the door component manufacturers, manufacturers' representatives, local building code and fire/life safety officials.

5. Develop a policy and procedure which describes in detail the facility's implementation of the MCU security coded doors within the facility structure, which shall include, but is not limited to, proper staff operation of the doors at all times, election of certified contractor(s) to continually

train/guide staff with the door systems and componentry, contingency plan related to door and establishment of a door monitoring, maintenance and repair schedule.

6. Retain a qualified contractor to perform inspections and testing on all of the four (4) MCU doorways every 3 months, and the remaining of the ingress/egress doors of the facility every 6 months, initiating immediately.

7. Maintain written documentation of all the corrective actions herein for review by Agency staff.

Should you have any questions, please call ..... Catherine Anne Avery, Survey and Certification Support Branch, at 850-412-4505 or Tikel Wedges-Phoenix, Health Facility Evaluator Supervisor, at 561-381-5846.

Regards,

Wedges-Phoenix, Supervisor

Arlene Mayo-Davis, Field Office Manager

Judi Christian

on 1-28-14 @ 4:30pm

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone (561) 381-5840; Fax (561) 496-5924