STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910377	03/14/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Grand Villa Of Delray East	14555 Sims Road Delray Beach, FL 33484	
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List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= J
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D
St - A - 0077 - 58a-5.019(1) Fac - Staffing Standards - Administrators S-S= J
St - A - 0090 - 58a-5.0191(11) Fac - Training - . S-S= G
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments

A Complaint Investigation Survey (CCR#2014002332) was conducted at Grand Villa of Delray East on . . to . . At the time of the survey, deficient practice was identified.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on record review, observation and interview, the assisted living facility failed to provide care and services appropriate to meet the needs of 2 out of 9 sampled residents(Resident #1 & Resident #5) . The assisted living facility failed to provide personal supervision, including two-hour checks, failed to follow their own policy and procedures and failed to provide awareness of the general health and safety of Resident #1 who was found expired.

Findings Include:

1) Record review of the incident report submitted to the Agency by the facility revealed that Resident #1 had passed on . . . . Further review found the facility only indicated Resident #1 was found "unresponsive on floor". Record review revealed the Agency's status of the report was "closed" as a result of the lack of details.

Record review of the police report dated . . revealed the deputy responded to the call at 7:56 AM and arrived at 8:05 AM for a . . . investigation. He indicated Resident #1 was unresponsive and was pronounced . . . . on the scene. He also indicated that a routine check every two hours was in Resident #1's charts.

Record review of the fire rescue report dated . revealed the call was received at 7:44:03 AM

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and was on location at 7:50:14 AM. Record review revealed a chief complaint of "unresponsive, pulseless, and apneic." Record review indicated the skin temperature was and pale. Record review revealed "female prone on the ground next to her bed. was unresponsive, pulseless and apneic. was noted to have and fixed and dilated pupils."

Record review of a statement written by Staff F on revealed she wrote she was in the laundry the Staff G said who was in the hospital and when she went to go do her rounds and check on Resident #1, she did not see her in her bed. She immediately remembered that it was Resident #1 who went to the hospital so she put on the paper that Resident #1 went to the hospital not knowing it was a different # really was in the hospital. She wrote, "the whole thing was a miscommunication".

Record review of a statement written by Staff G revealed it was dated (the date of the incident). Record revealed she wrote that Resident #1 came to the wellness center for her evening medications at 4:30 PM. At around 9:00 PM the memory care nurse called her to ask her to go to Resident #1's check on her air conditioner because Resident #1 was feeling hot. She gave Resident #1 her 9:00 PM medications and adjusted the air conditioner. She took the medication without difficulty and left with Resident #1 in her reclining chair. She wrote at the end of her shift, she gave the report to the night nurse and the two aides that Resident #10 in was in the hospital.

Record review of a statement written by Staff E (not dated) revealed Resident #1 was not acting out of the ordinary on the 3:00 PM - 11:30 PM shift where she provided care to Resident #1. She gave her a shower at 6:30 PM - 7:30 PM and checked in on her last at around 9:30 PM. During the 9:30 PM check, she found Resident #1 asleep in her recliner with her television on. She said at around 10:00 PM, Resident #1 called for someone to turn on her air conditioner and that was the last time she saw her.

Record review of the communication log revealed Resident #1 in the club on Further review revealed Resident #10 was admitted to the hospital due to on Record review found Resident #1 was not listed on the communication log as being sent out to the hospital on Record review found Resident #1 was unresponsive in the communication log on

Record review of the Resident check log revealed twelve current Residents were being checked on every two hours. Record review found Resident #1 was on the list. Record review revealed Resident #1 was listed as last checked on at 9:07 PM. Record review revealed "HOS" for Resident #1 for 11:00 PM, 1:00 AM, 3:00 AM, and 5:00 AM. Record review found Resident #1 was "found" on

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at 7:03 AM.

Record review of Resident #1's file revealed she was admitted to the facility on Record review found a Resident condition log which revealed on at 7:00 AM " Resident found in apartment by aide on the floor unresponsive. Resident was laying on her neck with her feet up in the air in between the bed and the chair. Supervisor notified and nurse on duty called to assist. Record review of Resident #1's condition log revealed Resident #1 had her most recent documented on and

Record review of Resident #1's Medication Observation Record (MOR) confirmed that Resident #1 received her 9:00 PM medications on 20 mg (milligram) tablet and z 0.004xopth 2.5 (eye drops).

Record review of Resident #1's health assessment, dated revealed Resident #1 uses a walker, needs assistance with all activities of daily living (ADL's), and is a risk. Record review revealed Resident #1 needed daily observation of whereabouts.

Record review of an elopement assessment of Resident #1 dated revealed "Resident requires a lot of redirection and is Resident requires increased staff monitoring due to decreased mobility. Resident can remain in in AL but family should be informed about up coming need or exit controlled unit".

Record review of photographic evidence obtained of Resident #1's body found the entire right side of her face was black and blue from her chin to her ear, including her ear. Record review found one of her arms were also black and black.

Record review revealed the facility failed to follow proper policy and procedure. Record review revealed that approximately 40 minutes had passed from the time Staff A found Resident #1 at approximately 7:03 AM until the time the facility contacted emergency medical services (called 911). Record review of the facility's walkie-talkie log revealed Staff A signed out a walkie-talkie on

2) Observations on at approximately 1:35 PM found the Resident #1 located on the left side of Observations found a bed on the left wall in the middle of the Observations found a quarter bed rail as well as a hand rail on the left side of the bed (closest to the window). Observations found a reclining chair against the left wall between the window and the bed. Observations found the space between the bed and the reclining chair was approximately one and a half

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feet. Observations found was approximately 78 steps away from the wellness center.

Observations on at approximately 2:50 PM found the daughter of Resident #1 and the Administrator speaking in the hallway of the second floor. Observations found the daughter was visibly upset and said to the Administrator "to stop lying to her". Observations found the daughter stated that she called the doctor's office and they told her they were not present at the facility after the of her mother and that her mother from breaking her neck and falling. She stated the police officer told that to the doctor's office. The daughter stated she was even told by the staff that her mother broke her neck, and Observations found the daughter was upset that the details of her mother's were held from her.

3) In an interview with the Administrator on at approximately 10:04 AM, she stated that Resident #1 last Wednesday . She stated she is still conducting an investigation. She stated an [source] came last Friday. She stated she was asking about Resident #1. She stated she is doing her investigation right now but she knows at around 7:00 AM in the morning, Staff A, went into Resident #1's apartment and found her on the floor and got a supervisor. She stated Staff A determined that Resident #1 was unresponsive and got a supervisor who contacted another supervisor. She stated between her and memory care nurse, they evaluated that Resident #1 had passed. She stated she called 911 and when the paramedics came they determined that Resident #1 passed and they contacted the Sheriff's Office. She stated the police officer investigated and contacted Resident #1's primary care physician. She stated a police officer always comes on the scene until the funeral home comes. She stated she still does not have concrete evidence. She stated she cannot make an opinion of whether she but she as a result of her getting out of bed. She stated she called Resident #1's daughter but she was not in on Friday because she was moving. She stated Resident #1 had a half rail and she will speculate that she tried using it to get out of bed. She stated she thought Resident #1 may have "gotten caught and did a summersault". She stated this was Thursday , when the police officer was there.

In an interview with Staff A on at approximately 10:25 AM, she stated she works the morning shifts (6:00 AM to 2:30 PM). She stated she found Resident #1 on the floor at 7:03 AM on She stated she did not see Resident #1 in the bed but found her on the floor. She stated she went to get the nurse right away. She stated Resident #1 slept in a private . She stated Resident #1 was "ambulatory and had a good stance". She stated she had a side rail and it was raised. She stated when she found her she was really scared and got the nurse. She stated she only called her name and Resident #1 did not respond so she ran and got the nurse. She stated she ran and got Staff B. She stated she found her in the wellness center on the second floor. She stated she went back in there with Staff B. She stated she thinks she only took one minute to get her. She stated she does not remember

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much because she was scared. She stated she was not in the ..... the paramedics came. She stated she thinks Staff B called 911.

In an interview with the Administrator on ..... at approximately 10:41 AM, she stated she did not get a statement from Staff B. She stated Resident #1 was on a two hour check. She stated Staff F told her she thought Resident #1 was in the hospital.

In an interview with Staff B on ..... at approximately 10:46 AM, she confirmed that Resident #1 resided in ..... She stated Resident #1 has a ..... but they were in separate ..... She stated it is a two ..... She stated she got in a 6:00 AM that morning. She stated she was in the wellness center passing medications when Staff A came in. She stated Staff A implied that Resident #1 was not breathing. She stated they saw Resident #1 on the side of the bed. She stated Resident #1 was ..... when she touched her. She stated it looked like it had been a few hours since she passed. She stated Resident #1 was stiff. She stated she took a ..... cuff but did not use it because she touched her and that was it. She stated she got the memory care nurse who worked over night. She stated it was a little after 7:00 AM when Staff A got her. She stated it takes her not even a minute to get to Resident #1's ..... the wellness center. She stated Resident #1 was on the floor and her "body was kind of in a ball". She stated she could not see her face because "her bottom half was on top". She stated it was like she flipped out of the bed. She stated she had a bed rail in a raised position. She stated she did not get caught in the bed rail. She stated she couldn't ' t see her neck because her body was folded in half. She stated she then ran down to the memory care unit and grabbed the nurse from the night shift. She stated she also grabbed Staff D. She stated Staff A stayed with Resident #1 while she got the nurse. She stated around 7:30 AM, Staff D entered Resident #1's ..... She stated there is not a supervision issue during the day, but she cannot speak for what happens at night.

In an interview with the Administrator on ..... at approximately 10:57 AM, she stated she has not gotten a statement from Staff D. She stated, " if you came an hour later she would have had more done". She stated she was not in on Friday to do an investigation. She stated the facility had twelve Residents on two hour checks and Resident #1 was one of them. She stated now there are eleven Residents. She stated Resident #1 was obviously taken care of on the 3-11 PM shift. She stated Staff F maintains that she was told by Staff G the wrong information. She stated Staff F was double thinking herself. She stated Staff F told her Resident #1's bed was made so she thought Resident #1 was in the hospital because that is what Staff G told her. She stated she thought that maybe Resident #1 went into Resident #7 ..... She stated Resident #1 was found on the other side of the bed and Staff F could not see her on the floor when she opened the door. She stated Staff F maintains that she went in there at 11:00 PM and the bed was made and Resident #1 was not in there. She stated the only time Staff F

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went into Resident #1's at 11:00 PM. She stated she does not know why Staff F was in there just once. She stated "it still is not gelling". She stated Resident #10 was the Resident that went to the hospital that night. She stated Resident #10 was in which is two doors away from Resident #1. She stated there is a communication log for Residents that go to the hospital. She stated Staff F told her she checked on Resident #1 once and her bed was made so she believed she was the Resident in the hospital. She stated sometimes Resident #1 goes into other Resident at night because she did not like being alone.

In an interview with the Administrator on at approximately 11:16 AM, she stated she did not know why Staff G would be talking about someone in the hospital. She stated Staff G is just "a medtech and only gives out medications".

In an interview with Staff C on at approximately 11:22 AM, she stated she keeps the communication log if Residents go to the hospital, have a medication change, or if there are any complaints. She stated she also documents in the communication log. She stated she is not the only one that writes in it. She stated the person who is dealing with the Resident writes in it. She stated the of Resident #1 appeared to be written by a medtech. She stated Resident #1 was trying to sit down and missed the chair. She stated Resident #1 has had about three She stated she heard that they found Resident #1 in her She stated she knows it was a but does not know anything else. She stated there are two people that work at the facility at night on the second floor. She stated if the Resident and cannot reach the call light it would be really hard to know if the Resident She stated if they do not have an alert bracelet it would have to be if they are going on rounds or passing by. She stated Resident #1 was supposed to be watched every two hours. She stated there was an incident that night and someone thought she was in the hospital. She stated there is not a supervision issue it was a miscommunication issue.

In an interview with Staff D on at approximately 11:29 AM, he stated he was in the memory care unit and one of the medtech's came up to him and said one of the Residents had He stated he found Resident #1 on the other side of the bed. He stated he was unable to see her when he opened the door. He stated there was no Staff in there when he walked in. He stated he believes that the bed was not completely made and looked like someone had been in it. He stated it was half and half. He stated it was roughly 7:10 AM when Staff B got him. He stated he had to walk around the bed in order to see Resident #1 on the floor. He stated she was in a tumble position and not lying flat. He stated he did not touch her at all. He stated he is not aware of anyone assessing her to see if she was breathing. He stated when he saw her, he advised the Staff not to touch her but to call 911. He stated there looked like there was a little pooled on her forehead. He stated he did not call 911 and does not know who called 911. He again stated when he got into the Staff were present.

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In an interview with the Administrator on at approximately 12:01 PM, she stated Resident #1's primary care physician was notified that day. She stated Resident #1's primary care physician is the physician that comes to the facility.

In an interview with the Administrator on at approximately 12:10 PM, she stated that the facility had been previously put under a plan of correction (POC). She stated the facility has not completed the plan of correction and they have not implemented any changes in the two hour check system. She stated they are currently tightening the system so they have a better awareness of people's comings and goings. She stated no Resident was taken off the two hour check list.

In an interview with both the son and daughter of Resident #1 on at approximately 1:43 PM, the son stated that the daughter was Resident #1's power of attorney (POA). The daughter stated her mother was getting old but when the facility called to say her mother had passed, the Administrator told her she had some bad news and she does not remember her words, but she said her mother passed that morning or during that night. She stated she the police officer took the phone from the Administrator and he said to them that she from an age related and her probably gave away. The daughter stated her mother would get up in the middle of the night to use the She stated she was notified by the [source] that she and the facility did not notify her about that. She stated they did not know if she passed in bed or she on the floor. She stated the call from the [source] shocked her. She stated the [source] inquired if Resident #1 broke her neck. She stated after she spoke to the [source], she was very upset and called the Administrator; it was then that she told her Resident #1 on the floor. She stated she told her she did not know if she broke her neck but she was found on the floor. She stated the Administrator told her they found Resident #1 on one of the shifts. She stated Resident #1 had a bed rail but the bed rail was not on the right side. She stated it was supposed to be on the other side. She stated it was put on by the store and Resident #1 cried that she needed it changed to the other side so she could have access to the her walker. She stated Resident #1 claimed it was not on the side that she wanted. She stated it had been on for about a week. She stated she does not like that she was not told the truth. She stated she was told that they walked around every couple of hours to look at the patients but does not know if that happened. She stated Resident #1 could have used a little more supervision but whether she got it or not she does not know. She stated they were left in the dark about what happened. She stated the sheriff even told them that she in bed. She stated she is not sure if the doctor signed a certificate. She stated the doctor was not around when she passed. She stated Resident #1 could communicate her needs. She stated they had a phone in Resident #1's they just bought her. The son stated that the night before she was found she called him to tell him that she needed the air turned on because she was uncomfortable. He stated he told her to call downstairs and the facility will adjust it for her. She stated that once in a while Resident #1 had

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someone that showered her that was not nice. She stated she showered three times a week. She stated if you asked questions some would not talk to her. She stated she does not have any of the names of the Staff though. She stated the facility used to always call when Resident #1 She stated Resident #1 had a history and it started getting worse. She stated she a week before in the dining she could not get a hold of chair. She stated she was going to ask the doctor if she needed to go to a wheelchair. She stated Resident #1 used a walker but had no problem walking.

In an interview with Staff A on at approximately 2:40 PM, she stated she could not see Resident #1 on the floor from the door. She stated she found Resident #1 in between the bed and the recliner.

In an interview with the daughter of Resident #1 on at approximately 3:22 PM. She stated she knew her mother's routine very well. She stated she would be in the recliner until about 10:00 PM watching television. She stated she even knew she would watch [name of the show] and then would go to bed.

In an interview with Staff E on at approximately 3:25 PM, she stated she works the 3 PM to 11:30 PM shift. She stated she bathed Resident #1 from 6:30 PM to about 7:30 PM the night she passed. She stated she bathed her for about an hour. She stated Resident #1 was acting normal. She stated Resident #1 was very talkative. She stated she did the two hour checks and she saw Resident #1 at around 9:15 PM. She stated she was checking in on her because she was a two hour check Resident. She stated at the time she observed her sitting in the recliner. She stated she had a tendency to unmake the bed. She stated when she first went in at 3:00 PM, Resident #1's bed was made. She stated, for the two hour checks, if the Resident is not in the is supposed to go look for them. She stated Resident #1 was on the special list to watch. She stated Resident #1 was in the club of the time. She stated she would not go to the club she was in her pajamas. She stated she put Resident #1 in her pajamas after the shower. She stated she did not believe Resident #1 went to another Resident night. She stated Resident #1 would be in three places; the club , the dining her . She stated she never knew she went into any Resident her own. She stated she would find her in the recliner or her bed. She stated sometimes if you put her in the bed she would try to get up even though she was afraid to . She stated Resident #1 would tell her that. She stated when she went into Resident #1's around 9:15 PM, she had unmade her bed and she did not want her to touch it. She stated she would fold the covers over and if she tried and pull it back, Resident #1 would get mad at her. She stated she was dozing off a little bit when she saw her. She stated she peaked in and that ' s it. She stated she did not do a thorough observation but she could tell she was breathing. She stated she went in at around 10:00 PM and she was sitting on her bed. She stated she was facing the door not the window. She stated her thermostat was outside of the

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She stated she does not remember if the television was on but the light was on and the door was slightly open. She stated Resident #1 wanted the air on because she said it was too hot. She stated she would not tell anyone that Resident #1 went to the hospital because she was sitting there. She stated Staff G is a good medtech but she does not know if she goes into Resident ... She stated Staff G does not do two hour checks. She stated she does the two hour checks.

In a phone conversation with the physician of Resident #1 on ... at approximately 9:05 AM, he stated he had not signed the ... certificate of Resident #1 but he plans on it. He stated he does not know the cause of her ... He stated he did hear rumors of how she ... He stated he heard she had a ... neck. He stated his office notified him of this yesterday. He stated he was notified on Sunday ... that Resident #1 passed. He stated he was not told at that point anything about her neck.

In a phone interview with the son of Resident #1 on ... at approximately 9:13 AM, he stated that yesterday was the first time he found out that his mother ... when she passed. He stated they did not know, but all the Staff knew, that they thought his mother went to the hospital and they did not check on her. He stated the facility neglected to do two hour checks on her. He stated that usually the facility would call the daughter of Resident #1 if she went to the hospital or if she ... He stated that everyone knew about it except for her family. He stated the doctor was not there nor did he make a report which was contrary to what they were told. He stated everyone in the facility knew there was a mistake made except for her family.

In a phone conversation with the physician of Resident #1 on ... at approximately 9:21 AM, he stated Resident #1 had mild ... and a mild stool issue but she had no major pressing medical issues. He stated she was recently diagnosed with ... and put on medications for it. He stated he started seeing her in ... of 2013. He stated the last time he saw her was on ... He stated the last time his office saw her was on ... when she was put on the ... medication. He stated when he gets cases like this where he cannot determine the cause of ... he will just put her diagnoses. He stated he cannot view her body nor can he verify if she had broken her neck or not.

In a phone interview with Staff F on ... at approximately 9:54 AM, she confirmed she works the night shifts at the facility. She stated her and another person on the floor are responsible for doing the two hour checks. She stated they take turns doing the two hours checks. She stated the night that Resident #1 ... it was her turn to do the rounds. She stated she went into Resident #1's ... she did not see her in there and automatically thought she went into hospital because a nurse told her a Resident went to the hospital. She stated she got ... She stated she started with her ... she did not see her in there. She stated she went her in there because she was on her list. She stated

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she thought it was her in the hospital. She stated the Staff G told her that Resident #1 was in the hospital in the laundry _____. She stated she forgot which _____ went to the hospital. She stated Staff G did not give her a name, she just gave her a _____. She stated when she found out it wasn ' t Resident #1, she found out it was the Resident in _____ in the hospital. She stated Resident #1 was in _____. She stated her bed was undone like someone went to bed. She stated it was halfway folded. She stated after she did not see Resident #1, she thought she was the one in the hospital. She stated she put her down on the list that she was in the hospital and she did not go in there the rest of the night. She stated the medtech's are supposed to let them know after the shift which Residents went to the hospital. She stated it is a verbal notification. She stated she does not know how the facility documents Residents in the hospital. She stated they told her verbally in the laundry _____ they are supposed to tell her when she was in the nursing station. She stated she was supposed to have a meeting but they did not have a meeting that night because they were doing laundry and the medtech just came up to them and told them. She stated the 3 PM to 11 PM Staff were supposed have a meeting when they get there at 11:00 PM but Staff G was still working so she did not tell us until a half hour later. She stated it was around a little before 11:30 PM; maybe 11:20 PM. She stated she saw Resident #1's recliner and she was not in it. She stated the hallway light was on but the television and _____ were off. She stated she found out in the morning that Resident #1 was not the one in the hospital. She stated when she was about to leave they called her to come and they told her to go into Resident #1's _____ She stated she goes home at 7:30 AM so it was around 7:25 AM. She stated Resident #1 was in the corner on the floor, and "it was weird", she did not expect it. She stated she was on the left side of the bed in the corner. She stated it looked like she was balled up. She stated it looked like she tried getting out of bed and got her foot stuck in the railing. She stated she did not see her foot but she was told that. She stated she just took a quick glance and it was a total _____. She stated the "maintenance guy went in there and touched her and said yes she is _____ she is _____. She stated she heard a rumor that Resident #1 had broken her neck. She stated she could not see Resident #1 from the door but had to walk over to the other side of the bed.

In a phone conversation with Staff G on _____ at approximately 10:35 AM, she confirmed she is a medtech and works the 3 PM to 11:30 PM shift on the second floor of the facility. She stated she usually gives a report but the girls are sometimes in the laundry _____ She stated she puts it on paper in the 24 hour book and she tells them as well. She stated all the girls know there is a 24 hours book. She stated she gave Resident #1 her medications and she was the one that put the air on for her. She stated she adjusted the thermostat and put it at 60 something degrees around 9:00 PM. She stated she gave medications to her at the same time. She stated when the nurse called her she said she would turn on the air when she went into to give Resident #1 her medications. She stated Resident #1 was sitting at the edge of the bed when she came in and she got up and sat in her recliner. She stated she gave her medications and eye drops every night. She stated about 9:00 PM was the last time she saw her. She

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stated when she left her she was still sitting in the recliner. She stated Resident #1 told her she was showered that evening. She stated Resident #1 does not go to another Resident ..... She stated when she was there, there was another Resident, Resident #8, in Resident #1's ..... She stated she was in there when she got there and when she left. She stated Resident #8 always told her what Resident #1 would need. She stated that when she told Staff F about the Resident in the hospital, she gave her the name and the ..... the Resident. She stated Staff F took her pen and wrote 282 on her own hand.

In a phone interview with the responding police officer on .. at approximately 11:26 AM, he stated he arrived to the facility around 8:00 AM. He stated it looked like Resident #1 attempted to get out of bed. He stated he was told she was checked on every two hours and she was last checked on a little after 7:00 AM. He stated the facility looked at her chart and told him Resident #1 was last checked at around 5:00 AM. He stated Resident #1 was found lying on the side of her bed. He stated she did have signs of . He stated she could have been there for three or four hours. He stated Resident #1 was up against the wall leaning to her left side. He stated he was told she had scoliosis of the spine. He stated he spoke to Resident #1's doctor and he told him he would sign the ..... certificate. He stated he spoke to Resident #1's family and told them Resident #1 attempted to get out of bed and her ..... gave out. He stated according the the facility, he was given an exact time she was checked on. He stated he was specifically told Resident #1 was checked on at 4:52 AM and was scheduled to be checked every two hours. He stated he did not see the paperwork though. He stated know that he knows this information, Resident #1's time of .... is skewed. He stated the threw him off but it now makes sense. He stated the rails were not straight up. He stated it appeared as if she attempted to use the bed rail to get up and .. over it.

In a phone conversation with the son of Resident #1 on .. at approximately 11:41 AM, he stated he viewed his mothers body and her right side of her face was puffy, and black and blue. He stated her legs were clean but he left arm was also . He stated she did not have scoliosis or curvature of the spine. He stated she would lean her head forward when she walked but she could pick it up if you asked her to do so.

In an interview with the Administrator on .. .. at approximately 2:20 PM, she stated she had not been able to conduct an investigation as of yet. She stated there is not much to do with it though. She stated it was a miscommunication between the 3-11 shift and the 11-7 shift. She stated Staff F could have mistakenly checked the wrong .... her bed was not made.

In an interview with the Administrator on .. at approximately 3:08 PM, she stated the communication log is a log that Staff use to see if a Resident is in the hospital. She stated it would have been helpful if Staff F checked that log. She stated if Staff F did not know about the

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communication log it would disappoint her.

In a phone interview with the Administrator on . . at approximately 1:45 PM, she stated she does not know who called 911 and does not know why it took approximately 40 minutes to do so.

In a phone interview with Staff A on . . at approximately 3:51 PM, she stated she did not touch Resident #1 when she found her nor did she do . . . . She stated she did not know if Resident #1 had a . . because the nurse is supposed to know that.

In a phone interview with Staff H on . . . . at approximately 4:37 PM, she stated she stated has been working at the facility since . 2013. She stated she works the 11 PM to 7 AM shift. She stated she is the only nurse at the facility at night time. She stated she works usually on the memory care side and she will go to the assisted living side if they need anything. She stated they come get her if they need anything and she will check on it and she would be the one to call 911. She stated when they found Resident #1; she was changing shifts and called 911 when she was notified. She stated she is not sure of what time she called 911. She stated she was notified after 7 AM in the morning about Resident #1. She stated she went to her . . saw she was on the side of the bed lying on the floor with her head down and her lower body on top and one of her legs were hanging in between the side rails. She stated she called 911 and the call dropped and 911 called back and the Resident care supervisor spoke to them and told them that Resident #1 needed a paramedic and they came after that. She stated she was there when the paramedics came. She stated the Administrator was there. She stated the Administrator told her to go home. She stated the paramedics came very fast within 5 minutes of calling. She stated that Staff B notified her and Staff D at the same time.

In an interview with Staff B on . . at approximately 2:17 PM, she stated in an emergency, she would see if the Resident is . see if they are breathing, and check the book to see if they are a . . and if they are she will not . . them. She stated if a Resident . . . out of bed she would check for injuries and see if they were in pain. She stated if they had any issues she would call 911. She stated it would be her responsibility to call 911. She stated she did not call 911 because she did not know what to do because it was the first time she encountered something like that so she went to get another nurse and they took it from there.

In an interview with the Resident care supervisor on . . at approximately 2:40 PM, she stated 2:40 PM, she has been working at the facility since . . 2014. She stated she came in the morning the day Resident #1 . She stated she would estimate that she came in around 7:35 AM. She stated at that point in time Staff did not call 911 as of yet. She stated she is not really sure

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why they did not. She stated she went upstairs and went into her called the Administrator. She stated while she was calling the Administrator, Staff H she was calling 911. She stated she does not know the process from the time Staff A found Resident #1 but she has to notify a supervisor which would be the nurse and she would call 911. She stated she believes that Staff A notified Staff H. She stated Staff H works in the memory care unit. She stated she is the night nurse and works in the memory care unit.

In an interview with Staff I on at approximately 2:58 PM, she stated she has been working at the facility since She stated if a CNA would go to her and say there is something wrong, she would have to stop doing what she was doing go check. She stated CNA's are supposed to stay and walkie-talkie her. She stated she would assess the Resident and ask them if they are in any pain. She stated she would call 911 immediately. She stated if they were not responsive she would call 911 immediately. She stated the CNA ' s are instructed to stay with the Resident and to call a medtech or nurse.

In an interview with Staff J on at approximately 3:03 PM, she stated the CNA is supposed to page her on the walkie-talkie and she would go and assist the Resident. She stated they are not supposed to leave the Resident. She stated a nurse is supposed to call 911 but if the nurse is already in the would go and call 911. She stated if she found a Resident not responsive she would call 911 immediately. She stated she usually gives a verbal report in the wellness center and they have a 24 hour book they write in for Residents that go to the hospital.

In an interview with Staff K on at approximately 3:15 PM, she stated she has been working at the facility for 9 years. She stated she is supposed to call the nurse right away if she finds a Resident in distress. She stated she would put on the emergency light in the She stated they have to stay with a Resident until the nurse gets there. She stated the nurse would call 911 if the Resident needed emergency services. She stated if a Resident went to the hospital she is supposed to check the 24 hour book.

In an interview with Staff L on at approximately 3:21 PM, she stated she has been working at the facility for 7 months. She stated if an emergency happened she would call the nurse. She stated she would use the walkie-talkie. She stated she is going to stay with the Resident and that is why they have the walkie-talkie. She stated when the nurse comes they would call 911 if they needed to. She stated she thinks if the Resident is not responsive they would call 911 immediately. She stated they are supposed to have a shift change meeting at the end of each shift in the wellness center. She stated there is a book that documents Residents that are in the hospital.

4) Observations on at approximately 3:49 PM, while walking the halls with the Administrator, found Resident #5 standing behind her wheelchair in the middle of a hallway on the second floor. Observations found Resident #5 was asking for assistance. Observations found no Staff around the halls to provide assistance. Observations found the Administrator had to assist Resident #5 into her wheelchair and took her into the wellness center.

In an interview with the Administrator on at approximately 2:40 PM, she acknowledged the findings.

Class I

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

Based on observation, record review and interview, the assisted living facility failed to ensure over the counter (OTC) products were secured and out of sight of other residents at all times.

Findings Include:

1) Observations on at approximately 3:45 PM, found a bottle of Over-The-Counter (OTC) pain reliever medication on the dresser in the living . Observations also found a bottle of OTC pain relief medication in the . Observations found neither medication bottle had a residents name on it. Observations found had two residents residing in the (
Resident #4 & #8). Observations found the had one

2) Record review revealed Resident #8 needed extra supervision and was on the facility's two hour check list.

3) In an interview with Resident #4 on at approximately 3:45 PM, she stated she gets her daily medications from the staff. She stated they hold onto her medications for her.

In an interview with the Administrator on at approximately 3:47 PM, she confirmed Resident #4 and Resident #8 both resided in . She stated she believes Resident #4 gets assistance with

self-administration of medication. After making a phone call, she stated that Resident #4 receives assistance with self-administration of medication.

Class III

0077-Staffing Standards - Administrators 58A-5.019(1) FAC

Based on record review, observation and interview, the Administrator failed to be responsible for the operation of the facility and the provision of adequate care to all residents.

Findings Include:

1) Record review of the facility's recent compliance history revealed the facility was cited at A0030 (Resident Care- Rights & Facility Procedures) at a class II from a complaint inspection completed on and . Record review found the facility was cited at A0025 (Resident Care-Supervision) at a class II from a complaint inspection completed on to . Record review of a revisit conducted at the facility on and found A0091 (Training-Documentation and Monitoring) and E203 (ECC- Staffing Requirements), both cited at a class III, were uncorrected.

Record review of the incident report submitted to the Agency by the facility revealed that Resident #1 had passed on . Further review found the facility only indicated Resident #1 was found "unresponsive on floor". Record review revealed the Agency's status of the report was "closed" as a result of the lack of details.

Record review of the police report dated revealed the deputy responded to the call at 7:56 AM and arrived at 8:05 AM for a investigation. He indicated resident #1 was unresponsive and was pronounced on the scene. He also indicated that a routine check every two hours was in Resident #1's charts.

Record review of the fire rescue report dated revealed that the call was received at 7:44:03 AM and was on location at 7:50:14 AM. Record review revealed a chief complaint of "unresponsive, pulseless, and apneic." Record review indicated the skin temperature was and pale. Record review revealed "female prone on the ground next to her bed. was unresponsive, pulseless and apneic. was noted to have and fixed and dilated pupils" .

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Record review of the resident check log revealed twelve current residents were being checked on every two hours. Record review found Resident #1 was on the list. Record review revealed Resident #1 was listed as last checked on . . at 9:07 PM. Record review revealed "HOS" for Resident #1 for 11:00 PM, 1:00 AM, 3:00 AM, and 5:00 AM. Record review found Resident #1 was "found" on . at 7:03 AM.

Record review revealed the facility failed to follow proper policy and procedure. Record review revealed that approximately 40 minutes had passed from the time Staff A found Resident #1 at approximately 7:03 AM, until the time the facility contacted emergency medical services (called 911).

Record review of email correspondence sent by the Administrator on . . she wrote, "in reviewing the statements I have from employees it appears there is some back and forth with getting and securing a supervisor to assess the situation because of the change of shift".

Record review of email correspondence sent by the administrator on . . she wrote, "the past year has had turnover of key personnel managers resulting in monthly trainings with no follow up paperwork, sign in sheets or certificates. It has been extremely challenging finding the right managers with commitment to ensure compliance with policies and procedures".

2) Observations on . . at approximately 2:50 PM found the daughter of Resident #1 and the Administrator speaking in the hallway of the second floor. Observations found the daughter was visibly upset and said to the Administrator "to stop lying to her". Observations found the daughter stated that she called the doctor's office and they told her they were not present at the facility after the . . . . of her mother and that her mother . from breaking her neck and falling. She stated the police officer told that to the doctor's office. The daughter stated she was even told by the staff that her mother broke her neck, . . . and . Observations found the daughter was upset that the details of her mother's . . were held from her.

3) In an interview with the Administrator on . . at approximately 10:04 AM, she stated that Resident #1 . last Wednesday . She stated she is still conducting an investigation. She stated she is doing her investigation right now but she knows at around 7:00 AM in the morning, Staff A, went into Resident #1's apartment and found her on the floor and got a supervisor. She stated staff A determined that Resident #1 was unresponsive and got a supervisor who contacted another supervisor. She stated between her and memory care nurse, they evaluated that Resident #1 had passed. She stated she called 911 and when the paramedics came they determined that Resident #1 passed and they contacted the Sheriff's Office. She stated the police officer investigated and contacted Resident

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#1's primary care physician. She stated a police officer always comes on the scene until the funeral home comes. She stated she still does not have concrete evidence. She stated she cannot make an opinion of whether she ... but she ... as a result of her getting out of bed. She stated she called Resident #1's daughter but she was not in on Friday because she was moving. She stated Resident #1 had a half rail and she will speculate that she tried using it to get out of bed. She stated she thought Resident #1 may have "gotten caught and did a summersault". She stated this was Thursday , when the police officer was there.

In an interview with the Administrator on .. at approximately 10:41 AM, she stated she did not get a statement from Staff B. She stated Resident #1 was on a two hour check. She stated Staff F told her she thought Resident #1 was in the hospital.

In an interview with the Administrator on .. at approximately 10:57 AM, she stated she has not gotten a statement from Staff D. She stated, " if you came an hour later she would have had more done". She stated she was not in on Friday to do an investigation. She stated she moving and could not come into the facility. She stated the facility had twelve residents on two hour checks and Resident #1 was one of them. She stated now there are eleven residents. She stated Resident #1 was obviously taken care of on the 3-11 PM shift. She stated Staff F maintains that she was told by Staff G the wrong information. She stated Staff F was double thinking herself. She stated Staff F, told her Resident #1's bed was made so she thought Resident #1 was in the hospital because that is what Staff G told her. She stated Resident #1 was found on the other side of the bed and Staff F could not see her on the floor when she opened the door. She stated Staff F maintains that she went in there at 11:00 PM and the bed was made and Resident #1 was not in there. She stated the only time Staff F went into Resident #1's ... at 11:00 PM. She stated she does not know why Staff F was in there just once. She stated "it still is not gelling". She stated Resident #10 was the resident that went to the hospital that night. She stated Resident #10 was in , which is two doors away from Resident #1. She stated there is a communication log for residents that go to the hospital. She stated Staff F told her she checked on Resident #1 once and her bed was made so she believed she was the resident in the hospital. She stated sometimes Resident #1 goes into other resident .. at night because she did not like being alone.

In an interview with the Administrator on at approximately 11:16 AM, she stated she did not know why Staff G would be talking about someone in the hospital. She stated Staff G is just "a medtech and only gives out medications".

In an interview with the Administrator on .. .. at approximately 12:01 PM, she stated resident #1's primary care physician was notified that day. She stated Resident #1's primary care physician is the physician that comes to the facility.

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In an interview with the administrator on [redacted] at approximately 12:10 PM, she stated that the facility had been previously put under a plan of correction (POC). She stated the facility has not completed the plan of correction and they have not implemented any changes in the two hour check system. She stated they are currently tightening the system so they have a better awareness of people's comings and goings. She stated no resident was taken off the two hour check list.

In an interview with both the son and daughter of Resident #1 on [redacted] at approximately 1:43 PM, the son stated that the daughter was Resident #1's power of attorney (POA). The daughter stated her mother was getting old but when the facility called to say her mother had passed; the Administrator told her she had some bad news and she does not remember her words, but she said her mother passed that morning or during that night. She stated the police officer took the phone from the Administrator; he said to them that she [redacted] from an age related [redacted] and her [redacted] probably gave away. She stated she was notified by the [source] that she [redacted] and the facility did not notify her about that. She stated they did not know if she passed in bed or she [redacted] on the floor. She stated the call from the [source] shocked her. She stated the [source] inquired if Resident #1 broke her neck. She stated after she spoke to the [source]she was very upset and called the administrator and it was then that she told her Resident #1 [redacted] on the floor. She stated she told her she did not know if she broke her neck but she was found on the floor. She stated the administrator told her they found Resident #1 on one of the shifts. She stated Resident #1 had a bed rail but the bed rail was not on the right side. She stated it was supposed to be on the other side. She stated it was put on by the store and Resident #1 cried that she needed it changed to the other side, so she could have access to the [redacted] her walker. She stated Resident #1 claimed it was not on the side that she wanted, it had been on for about a week. She stated she does not like that she was not told the truth. She stated she was told that they walked around every couple of hours to look at the patients but does not know if that happened. She stated Resident #1 could have used a little more supervision but whether she got it or not she does not know. She stated they were left in the dark about what happened. She stated the sheriff even told them that she [redacted] in bed.

In a phone conversation with the physician of Resident #1 on [redacted] at approximately 9:05 AM, he stated he had not signed the [redacted] certificate of Resident #1 at the time of the call but he plans on it. He stated he does not know the cause of her [redacted] and that their were rumors of how she [redacted] He stated he heard she had a [redacted] neck, his office notified him of this yesterday. He stated he was notified on Sunday [redacted] that Resident #1 passed and was not told at that point anything about her neck.

In a phone interview with the son of Resident #1 on [redacted] at approximately 9:13 AM, the following was revealed. He stated that yesterday was the first time he found out that his mother [redacted] when she passed. He stated they did not know, but all the staff knew, that they thought his mother went to the

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hospital and they did not check on her. The son stated, the facility neglected to do two hour checks on her. He stated that usually the facility would call the daughter of Resident #1, if she went to the hospital or if she . He stated that everyone knew about it except for her family. He stated the doctor was not there nor did he make a report which was contrary to what they were told. He stated everyone in the facility knew there was a mistake made except for her family.

In a phone interview with the responding police officer on at approximately 11:26 AM, the following was revealed. He arrived to the facility around 8:00 AM. Resident #1 looked as if she attempted to get out of bed. He stated he was told she was checked on every two hours and she was last checked on a little after 7:00 AM. The facility looked at her chart and told him Resident #1 was last checked at around 5:00 AM. He stated Resident #1 was found lying on the side of her bed; she did have signs of and that she could have been there for three or four hours. He stated Resident #1 was up against the wall leaning to her left side. He stated he was told she had scoliosis of the spine. He stated according the the facility, he was given an exact time she was checked on; he was specifically told Resident #1 was checked on at 4:52 AM and was scheduled to be checked every two hours. He stated he did not see the paperwork though. He stated now that he knows this information, Resident #1's time of is skewed. He stated the threw him off but it now makes sense.

In an interview with the administrator on at approximately 2:20 PM, she stated she had not been able to conduct an investigation as of yet. She stated there is not much to do with it though. She stated it was a miscommunication between the 3-11 shift and the 11-7 shift. She stated Staff F could have mistakenly checked the wrong her bed was not made. She stated she gave the [source] my contact information so she did not have to provide them same documentation twice.

In an interview with the Administrator on at approximately 3:08 PM, she stated the communication log is a log that staff use to see if a resident is in the hospital. She stated it would have been helpful if Staff F checked that log. She stated if Staff F did not know about the communication log it would disappoint her.

In a phone interview with the Administrator on at approximately 1:45 PM, she stated she does not know who called 911 and does not know why it took approximately 40 minutes to do so.

In a phone interview with the Administrator on at approximately 3:00 PM, she asked if she would be able to use the Agency's investigation for her 15-day report. After informed that she might not receive it within the timeframe, she inquired if she would be able to use the information obtained during the exit conference. She stated she will not be at the facility tomorrow if the surveyor should show up. She stated she has to close on her house and won't be able to be at the facility.

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In a phone interview with the Administrator on at approximately 3:59 PM, she stated she would not be available until Monday for she is will be closing on a house.

In an interview with the business office manager on at approximately 3:28 PM, she stated the last time training was offered by the facility was in of 2013. She stated it was She stated any staff hired after that day would not have training through the facility. She stated she sent an email to me on with all of the trainings she found of staff that worked on She stated that only two staff that worked on (the day in which resident #1 had been found expired) had training.

Class I

0090-Training - **58A-5.0191(11) FAC**

Based on interview and record review, assisted living facility failed to provide proper documentation that Training was completed and/or offered for a minimum of 4 out of 5 (Staff B, Staff D, Staff E, and Staff F) sampled Staff member reviewed.

Findings Include:

1) In a phone interview with the Administrator on at approximately 3:59 PM, she stated that both trainings requested could not be found. She stated she cannot provide me with something that she does not have.

In an interview with Staff B on at approximately 2:17 PM, she stated she is not sure if the facility has a policy on RO's.

In an interview with the Resident Care Supervisor on at approximately 2:40 PM, she stated she should know which residents have a but she is still in training and does not know the process.

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In an interview with Staff I on at approximately 2:58 PM, she stated the facility has not offered her training. She stated she has been working at the facility since of 2013.

In an interview with Staff L on at approximately 3:21 PM, she stated the facility has not offered her training. She stated she has been working at the facility for seven months. She stated she does not know where the residents RO's are kept (Staff L provides direct care to residents).

In an interview with the business office manager on at approximately 3:28 PM, she stated the last time training was offered by the facility was in of 2013. She stated it was She stated any staff hired after that day would not have training through the facility. She stated she sent an email to me on with all of the trainings she found of staff that worked on . She stated that only two staff that worked on (the day in which Resident #1 had been found expired) had training.

2) Record review of email correspondence sent by the facility on revealed 31 staff members worked on . Record review revealed the facility only sent two certificates of two separate staff members in which received training.

Record review of email correspondence sent by the facility on revealed the Administrator stated that she, "could not confirm. Had class offered but cannot secure proof" to an email in which she was asked if Staff A and Staff F had training.

Record review of an email sent by the facility on revealed there are 29 current Staff members which are working at the facility that were hired after of 2013. Record review revealed Staff B, Staff D, Staff E and Staff F were included in the 29 staff members mentioned above.

a)Record review of staff B revealed she was hired on . Record review revealed Staff B did not have any documentation to show she had the required training.

b) Record review of Staff D revealed he was hired on Record review revealed Staff D did not have any documentation to show he had the required training.

c) Record review of Staff E revealed she was hired on . Record review revealed Staff B did not have any documentation to show she had the required training.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910377	03/14/2014
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)		

d) Record review of Staff F revealed she was hired on [redacted]. Record review revealed Staff F did not have any documentation to show she had the required [redacted] training.

Class II

0152-Physical Plant - Safe Living Environ/Other 58A-5.023(3) FAC

Based on observation and interview, the assisted living facility failed to provide a safe living environment and an environment free of foul odors.

Findings Include:

1) Observations on [redacted] at approximately 3:30 PM found [redacted] was a resident for one resident. Observations found the [redacted] a strong [redacted]-like odor. Observations found the odor was so strong the surveyor had to exit the [redacted].

2) In an interview with the Administrator on [redacted] at approximately 3:31 PM, she acknowledged the foul-like odor and stated it was possibly coming from the mattress because of a lack of mattress [redacted].

Class III

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

RE: CCR #2014002332

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2014 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies no less than five days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after **2014** to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

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

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Delray Beach, FL 33484
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