STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910377	01/09/2015
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 - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= G
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments
Unannounced licensure complaint surveys, CCR #2014010051 and CCR #2014011399, were conducted on through at Grand Villa Of Delray East. The facility was not in compliance and had deficiencies found at the time of this visit for CCR #2014011399 at A-0010, A-0025 and A-0165 (Class II). The facility had no deficiencies related to complaint CCR #2014010051.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC
Based on record review, observation and interview, it was determined the facility failed to monitor the continued appropriateness of placement, for 1 out of 8 residents that resides in the facility (resident #22).

The findings include:

In an interview with resident #22 on at 2:25pm, she stated that she had lived in the facility since 2014 and she had substantial physical limitations due to a fused right knee and generalized She stated that her physical limitations made her move very slowly and she was used to performing her activities of daily living (ADLs) on her own, since it was difficult to engage the facility staff to supervise or observe her while performing her ADLs. She stated that she gave up attempting to call on the staff to assist her because it became too burdensome on them. She stated that she walked/ambulated, transferred, went to the toilet and dressed independently, without staff oversight and that about 3 weeks ago, she while attempting to transfer and ambulate to reach for her glasses on the counter inside her She stated that she injured her face when she and had to go to the hospital. She stated that at another previous time, she cut her left leg on a drawer in her she tried to dress herself. In an observation on at 2:30pm, the resident attempted to transfer from sitting in a stationary chair to standing and to reach for her rolling walker, but she was not able to safely stand up due to her fused right knee, which made her substantially unstable and she had to immediately sit back down in the stationary chair. The resident presented to be alert and oriented without any signs of at this time.

Review of resident #22'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 required physical and occupational services and needed monitoring for safety precautions. Review of the resident's health assessment dated on indicated that she required physical and occupational and OT) and skilled nursing services and needed "monitoring for safety" precautions. This health assessment indicated that she needed direct supervision with ambulation, dressing, toileting and transferring. Review of the resident's Medicaid assistive care services medical necessity

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evaluation dated on indicated that the resident needed individual assistance with her ADLs, including ambulation, transferring, toileting and dressing.

Review of resident #22's facility condition log dated on indicated that she in her 7:10 pm, she was from her arm and leg, and was transported to the hospital for further evaluation. The resident's condition log dated on indicated that the resident suffered a on her hand at 6:30pm while she attempted to stop the elevator door from closing, while ambulating without direct supervision and her injury was treated in the facility. The resident's condition log dated on indicated that the resident was found on the floor next to her bed by a staff member and suffered no apparent injury. This note indicated that the resident attempted to undress without direct supervision and slipped on the floor. The resident's condition log dated on indicated that she was found on the floor in her 9:45 pm, she was lying on her back from her face, and was transported to the hospital for further evaluation. This note indicated that the resident attempted to reach for her glasses before she slipped and on the floor. Review of the resident's assignment log dated on indicated that the resident needed a level of care that did not include direct staff supervision or observation with her ADLs including ambulation, dressing, and transferring. Further review of the resident's record did not yield information of any demonstrable facility-initiated intervention to actively reduce or prevent the resident's safety risk or increased resident monitoring.

In an interview with the resident care supervisor (RCS) on at 1:45 pm, she stated that she understood that resident #22 was mostly independent with her ADLs, including ambulation, dressing and transferring, without any need for direct staff supervision. She stated on at 4:30 pm that the facility did not implement any demonstrable interventions to reduce or prevent future accidents or for the resident after her hospitalizations on and She stated that the resident was evaluated and treated by through the home health agency (HHA) and that she was not aware if the resident received OT services as requested by the physicians on her health assessments dated on and She stated that besides the HHA staff reassessment log dated from to the facility did not have further documentation of the specific services extended to the resident and she did not describe further resident care extended by the facility.

In an interview with the caregiver on at 3:50 pm, she stated that she responded to resident #22's on immediately after she was called on by another caregiver at about 9:30 pm. She stated that the resident was found on the floor in her the resident was lying on her back with her nose and head and the rolling walker was toppled over resting on or by the resident's head. She stated that the resident described that she was trying to reach for something and was not being supervised by anyone before she She stated that she understood the resident to be independent with her ADLs, not needing direct supervision, including toileting, transferring and ambulation. She did not explain how she engaged the resident to call for facility staff assistance or how she would anticipate the resident's needs.

In an interview with resident #22's physician on at 2:15 pm, he stated that the resident initially needed assistance with her ADLs in and 2014 due to her fused right knee and her previous hip replacements. He stated that the resident had an extensive medical history, including surgeries like a total knee replacement and hip replacements, and severe , which further complicated her functional status. He stated that he relied on the services to further assess the resident's functional status and he initially ordered for the patient to receive services on but did not readily have

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any or OT services information to ascertain the resident's complete functional status. He stated that this resident's case was of a "very debilitated woman who was significantly infirmed" and he was not aware of the specific safety precautions the facility established for the resident because he did not have anything documented representing that the facility provided him with such information.

In an interview with resident #22's physical assistant and home health agency (HHA) administrator on at 4:00pm, they stated that their HHA was responsible to deliver services for resident #22 and the resident was initially evaluated on from orders of the physician for abnormal gait , generalized muscle and functional decline. They stated that the resident initially ambulated less than 25 feet with minimal assistance using a rolling walker (RW), needed set-up assistance with , assistance with dressing to maintain her safety, minimal assistance with bathing and contact guard assistance for transfers. They stated that the resident participated in 10 sessions and that on , she requested to stop services because she believed she no longer needed it. They stated that the evaluations and treatments were continually communicated to the facility nurses at the facility and the facility was given the services written reports, as attached. They stated that the resident had been instructed by services to use call bell system and to properly use her RW. They stated that on , the resident's evaluation indicated that she ambulated 80 feet with contact guard assistance and that the physical did not recommend the resident to use a cane for ambulation. They stated that the physician ordered services once again on due to the resident's 2 recent the latter part of 2014. They stated that on the evaluation on , the resident was capable of ambulating 25 feet, 2 times with standby assistance using the RW and needed contact guard assistance for transfers, toileting and showers. They stated that the resident had no functional range of motion on her right knee due to a and believed that she was currently in a slow progression to standby assistance/supervision with ambulation and transfer to maintain her safety. They stated that they are not aware of the facility's specific efforts to supervise the resident with her ADLs or personal care and that the facility had not discussed in totality with the HHA staff the resident's recent injuries or . In an interview with the HHA administrator on at 9:45 am, she stated that the HHA staff conducted resident case conferences with the facility staff, including the RCS, approximately 3 to 4 times per month and shared daily reports as needed. She stated that the written reports are handed to the facility nursing staff and the facility administrator requested the HHA to help develop a facility generalized resident safety program about a month ago, but this was not followed up on by the facility. She stated that the HHA had not received any physician order from the facility to provide OT services to the resident.

Review of resident #22's hospital emergency department (ED) record dated on indicated that she arrived to the hospital by emergency transportation due to injuries from a while ambulating in the facility. This record indicated that the hospital instituted prevention measures for the resident and she sustained to her right and knee. Further review of this record indicated that her symptoms were moderate, she was prescribed pain medications and care, and was discharged from the hospital ED back to the facility. Review of the hospital ED record dated on indicated that she arrived to the hospital by emergency transportation due to injuries from a while standing over her RW in the facility. This record indicated that the

hospital instituted prevention measures for the resident and she sustained face, neck and scalp closed head injury and . Further review of this record indicated that the resident had and

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tenderness to her neck area, she was prescribed care and diagnostic imaging to rule out , and was discharged from the hospital ED back to the facility.

In an interview with the regional operations manager on at 2:05 pm, she stated that the facility performed investigations on the events of resident #22, but it is not at liberty to share those investigations with the Agency, and that she was not aware of any reassessment resident #22 needed for the facility to reconsider her continued residency.

Class II

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

Based on observation, interview and record review, it was determined the facility failed to adequately provide care and services to meet the needs of 6 out of 8 at-risk residents (resident #s 20, 21, 22, 23, 24 and 25) by not providing their assessed activities of daily living (ADLs) supervision and specialized safety precaution requirements.

The findings include:

a) In an interview with resident #22 on at 2:25pm, she stated that she had lived in the facility since 2014 and she had substantial physical limitations due to a fused right knee and generalized She stated that her physical limitations made her move very slowly and she was used to performing her ADLs on her own, since it was difficult to engage the facility staff to supervise or observe her while performing her ADLs. She stated that she gave up attempting to call on the staff to assist her because it became too burdensome on them. She stated that she walked/ambulated, transferred, went to the toilet and dressed independently, without staff oversight and that about 3 weeks ago, she while attempting to transfer and ambulate to reach for her glasses on the counter inside her She stated that she injured her face when she and had to go to the hospital. She stated that at another previous time, she cut her left leg on a drawer in her she tried to dress herself. In an observation on at 2:30pm, the resident attempted to transfer from sitting in a stationary chair to standing and to reach for her rolling walker, but she was not able to safely stand up due to her fused right knee, which made her substantially unstable and she had to immediately sit back down in the stationary chair. The resident presented to be alert and oriented without any signs of at this time.

Review of resident #22'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 required physical and occupational services and needed monitoring for safety precautions. This health assessment indicated that she needed direct supervision with ambulation, dressing, toileting and transferring. Review of the resident's health assessment dated on indicated that she required physical and occupational and OT)and skilled nursing services and needed "monitoring for safety" precautions. This health assessment indicated that she needed direct supervision with ambulation, dressing, toileting and transferring. Review of the resident's Medicaid assistive care services medical necessity evaluation dated on indicated that the resident needed individual assistance with her ADLs,

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including ambulation, transferring, toileting and dressing.

Review of resident #22's facility condition log dated on indicated that she in her 7:10pm, she was from her arm and leg, and was transported to the hospital for further evaluation. The resident's condition log dated on indicated that the resident suffered a on her hand at 6:30pm while she attempted to stop the elevator door from closing, while ambulating without direct supervision, and her injury was treated in the facility. The resident's condition log dated on indicated that the resident was found on the floor next to her bed by a staff member and suffered no apparent injury. This note indicated that the resident attempted to undress without direct supervision and slipped on the floor. The resident's condition log dated on indicated that she was found on the floor in her 9:45pm, she was lying on her back from her face, and was transported to the hospital for further evaluation. This note indicated that the resident attempted to reach for her glasses before she slipped and on the floor. Review of the resident's assignment log dated on indicated that the resident needed a level of care that did not include direct staff supervision or observation with her ADLs including ambulation, dressing, and transferring. Further review of the resident's record did not yield information of any demonstrable facility-initiated intervention to actively reduce or prevent the resident's safety risk or increased resident monitoring.

In an interview with the resident care supervisor (RCS) on at 1:45pm, she stated that she understood that resident #22 was mostly independent with her ADLs, including ambulation, dressing and transferring, without any need for direct staff supervision. She stated on at 4:30pm that the facility did not implement any demonstrable interventions to reduce or prevent future accidents or for the resident after her hospitalizations on and She stated that the resident was evaluated and treated by through the home health agency (HHA) and that she was not aware if the resident received OT services as requested by the physicians on her health assessments dated on and She stated that besides the HHA staff reassessment log dated from to , the facility did not have further documentation of the specific services extended to the resident and she did not describe further resident care extended by the facility.

In an interview with the caregiver on at 3:50pm, she stated that she responded to resident #22's on immediately after she was called on by another caregiver at about 9:30pm. She stated that the resident was found on the floor in her the resident was lying on her back with her nose and head and the rolling walker was toppled over resting on or by the resident's head. She stated that the resident described that she was trying to reach for something and was not being supervised by anyone before she She stated that she understood the resident to be independent with her ADLs, not needing direct supervision, including toileting, transferring and ambulation. She did not explain how she engaged the resident to call for facility staff assistance or how she would anticipate the resident's needs.

In an interview with resident #22's physician on at 2:15pm, he stated that the resident initially needed assistance with her ADLs in and 2014 due to her fused right knee and her previous hip replacements. He stated that the resident had an extensive medical history, including surgeries like a total knee replacement and hip replacements, and severe , which further complicated her functional status. He stated that he relied on the services to further assess the resident's functional status and he initially ordered for the patient to receive services on , but did not readily have any or OT services information to ascertain the resident's complete functional status. He stated that this

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resident's case was of a "very debilitated woman who was significantly infirmed" and he was not aware of the specific safety precautions the facility established for the resident because he did not have anything documented representing that the facility provided him with such information.

In an interview with resident #22's physical assistant and home health agency (HHA) administrator on at 4:00pm, they stated that their HHA was responsible to deliver services for resident #22 and the resident was initially evaluated on from orders of the physician for abnormal gait, generalized muscle and functional decline. They stated that the resident initially ambulated less than 25 feet with minimal assistance using a rolling walker (RW), needed set-up assistance with assistance with dressing to maintain her safety, minimal assistance with bathing and contact guard assistance for transfers. They stated that the resident participated in 10 sessions and that on she requested to stop services because she believed she no longer needed it. They stated that the evaluations and treatments were continually communicated to the facility nurses at the facility and the facility was given the services written reports, as attached. They stated that the resident had been instructed by services to use call bell system and to properly use her RW. They stated that on the resident's evaluation indicated that she ambulated 80 feet with contact guard assistance and that the physical did not recommend the resident to use a cane for ambulation. They stated that the physician ordered services once again on due to the resident's 2 recent the latter part of 2014. They stated that on the evaluation on the resident was capable of ambulating 25 feet, 2 times with standby assistance using the RW and needed contact guard assistance for transfers, toileting and showers. They stated that the resident had no functional range of motion on her right knee due to a and believed that she was currently in a slow progression to standby assistance/supervision with ambulation and transfer to maintain her safety. They stated that they are not aware of the facility's specific efforts to supervise the resident with her ADLs or personal care and that the facility had not discussed in totality with the HHA staff the resident's recent injuries or In an interview with the HHA administrator on at 9:45am, she stated that the HHA staff conducted resident case conferences with the facility staff, including the RCS, approximately 3 to 4 times per month and shared daily reports as needed. She stated that the written reports are handed to the facility nursing staff and the facility administrator requested the HHA to help develop a facility generalized resident safety program about a month ago, but this was not followed up on by the facility. She stated that the HHA had not received any physician order from the facility to provide OT services to the resident.

Review of resident #22's hospital emergency department (ED) record dated on indicated that she arrived to the hospital by emergency transportation due to injuries from a while ambulating in the facility. This record indicated that the hospital instituted prevention measures for the resident and she sustained to her right and knee. Further review of this record indicated that her symptoms were moderate, she was prescribed pain medications and care, and was discharged from the hospital ED back to the facility. Review of the hospital ED record dated on indicated that she arrived to the hospital by emergency transportation due to injuries from a while standing over her RW in the facility. This record indicated that the hospital instituted prevention measures for the resident and she sustained face, neck and scalp closed head injury and Further review of this record indicated that the resident had and tenderness to her neck area, she was prescribed care and diagnostic imaging to rule out , and

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was discharged from the hospital ED back to the facility.

b) In an interview with resident #23 on at 11:30am, she stated that she had been living in the facility since 2014 and that the staff members are socially very nice and pleasant. She stated that she needed assistance with dressing, but was not offered help with this besides having a facility staff member come every morning to lay out some clothing on her bed for her to put on herself. She stated that since the facility staff is not engaged in assisting her with her ADLs, including ambulation and transferring, it is difficult for her to continually have to tell the direct care staff what she needs every day. She stated that about a month ago, she in her attempting to stand up from her stationary chair. She stated that she got tripped up on her chair leg and on her shoulder, which was her previously operated shoulder and it became painful after the

Review of resident #23's record indicated that she was admitted to the facility on with diagnoses including and lower extremities paresthesias. Review of her health assessment dated on indicated that she must be on special precautions and must use her walker while ambulating. This health assessment indicated that she needed assistance with ambulation, dressing, bathing and transferring, with comment on her needing assistance of 1 person for bathing and dressing. Review of the resident condition log dated on indicated that the resident by tripping over a chair in her 12:00pm and no injury was noted. Further review of the resident's record did not yield information of any demonstrable facility-initiated intervention to actively reduce or prevent the resident's risk.

In an interview with staff nurse on at 1:55pm, she stated that she responded to resident #23 when she on and she understood that the resident was independent with her ADLs, including ambulation and transferring, without needing any staff assistance. She stated that upon her review of the resident's health assessment on , she understood that the resident needed staff assistance with ambulation, dressing, bathing and transferring, but was on the physician comments that the resident needed assistance ambulating but may "walk independently with assistance from walker" and needed assistance transferring "from walker to transfer". She stated that the facility did not seek to get a clarification on these physician comments and she still understood that any required ADL assistance meant that the resident must receive personal assistance from a staff member. She stated that she was not aware of any precaution interventions applied to the resident due to her on

In an interview with the regional operations manager on at 2:05pm, she stated that she interpreted resident #23's health assessment dated on as attached, that the resident was independent with ambulation and transferring, and only needed the assistance from the walker, as a durable medical device, to perform those tasks. She stated that it was clear language, implying that the staff needed no clarification to identify the services needed.

c) In an observation on at 10:50am, resident #21 was walking independently without any staff supervision in the main lobby. Review of the resident's record indicated that he was admitted on with diagnoses including Paget's of the bone, and Review of the resident's health assessment dated on indicated that he had physical limitations of and gait and needed special precautions. Further review of the health assessment's ADL evaluation indicated that the resident needed supervision with ambulation, dressing, toileting and transferring without explanation on

how the resident would receive this supervision.

d) In an observation on at 10:55am, resident #24 was walking independently without any staff supervision in the main lobby. Review of the resident's record indicated that he was admitted on with diagnoses including , mild and . Review of the resident's health assessment dated on indicated that he needed supervision with all of his ADLs, including ambulation and transferring.

e) In an observation on at 12:05pm, resident #25 was walking independently without any staff supervision in the main hallway near the dining . Review of the resident's record indicated that she was admitted on with diagnoses including previous lumbar compression and . Review of the resident's health assessment dated on indicated that she needed special precautions and needed supervision with ambulation.

f) In an observation on at 12:30pm, resident #20 was walking independently without any staff assistance in the main dining . Review of the resident's record indicated that she was admitted on with diagnoses including , , , and lower extremity . Review of this resident's undated health assessment indicated that she had physical limitations that required her to use a walker for mobility and needed precautions, and needed assistance with ambulation, bathing, dressing, toileting and transferring. Further review of the health assessment's ADL evaluation indicated that the resident used a walker for mobility without explanation on how the resident would receive assistance with ambulation, as concurrently assessed. Further review of the resident's record did not indicate that the facility addressed her undated health assessment.

Class II

0165-Risk Mgmt & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on observation, interview and record review, the facility failed to notify the agency of multiple incidents, including , that required 1 of 8 sampled residents (Resident #22) to be transferred temporarily to a facility providing a higher level of care.

The findings include:

In an interview with resident #22 on at 2:25pm, she stated that she had lived in the facility since 2014 and she had substantial physical limitations due to a fused right knee and generalized . She stated that her physical limitations made her move very slowly and she was used to performing her ADLs on her own, since it was difficult to engage the facility staff to supervise or observe her while performing her ADLs. She stated that she gave up attempting to call on the staff to assist her because it became too burdensome on them. She stated that she walked/ambulated, transferred, went to the toilet and dressed independently, without staff oversight and that about 3 weeks ago, she while attempting to transfer and ambulate to reach for her glasses on the counter inside her . She stated that she injured her face when she and had to go to the hospital. She stated that at another previous time, she cut her left leg on a drawer in her she tried to dress herself. In an

observation on at 2:30pm, the resident attempted to transfer from sitting in a stationary chair to standing

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and to reach for her rolling walker, but she was not able to safely stand up due to her fused right knee, which made her substantially unstable and she had to immediately sit back down in the stationary chair. The resident presented to be alert and oriented without any signs of [redacted] at this time.

Review of resident #22's record indicated that she was admitted to the facility on [redacted] with diagnoses including [redacted] and [redacted]. Review of the resident's health assessment dated on [redacted] indicated that she required physical and occupational [redacted] services and needed monitoring for safety precautions. This health assessment indicated that she needed direct supervision with ambulation, dressing, [redacted] toileting and transferring. Review of the resident's health assessment dated on [redacted] indicated that she required physical and occupational [redacted] and OT)and skilled nursing services and needed "monitoring for safety" precautions. This health assessment indicated that she needed direct supervision with ambulation, dressing, [redacted] toileting and transferring. Review of the resident's Medicaid assistive care services medical necessity evaluation dated on [redacted] indicated that the resident needed individual assistance with her ADLs, including ambulation, transferring, [redacted] toileting and dressing.

Review of resident #22's facility condition log dated on [redacted] indicated that she [redacted] in her [redacted] 7:10pm, she was [redacted] from her arm and leg, and was transported to the hospital for further evaluation. The resident's condition log dated on [redacted] indicated that the resident suffered a [redacted] on her hand at 6:30pm while she attempted to stop the elevator door from closing, while ambulating without direct supervision, and her injury was treated in the facility. The resident's condition log dated on [redacted] indicated that the resident was found on the floor next to her bed by a staff member and suffered no apparent injury. This note indicated that the resident attempted to undress without direct supervision and slipped on the floor. The resident's condition log dated on [redacted] indicated that she was found on the floor in her [redacted] 9:45pm, she was lying on her back [redacted] from her face, and was transported to the hospital for further evaluation. This note indicated that the resident attempted to reach for her glasses before she slipped and [redacted] on the floor. Review of the resident's assignment log dated on [redacted] indicated that the resident needed a level of care that did not include direct staff supervision or observation with her ADLs including ambulation, dressing, [redacted] and transferring. Further review of the resident's record did not yield information of any demonstrable facility-initiated intervention to actively reduce or prevent the resident's safety risk or increased resident monitoring.

In an interview with the resident care supervisor (RCS) on [redacted] at 1:45pm, she stated that she understood that resident #22 was mostly independent with her ADLs, including ambulation, dressing and transferring, without any need for direct staff supervision. She stated on [redacted] at 4:30pm that the facility did not implement any demonstrable interventions to reduce or prevent future accidents or [redacted] for the resident after her hospitalizations on [redacted] and [redacted]. She stated that the resident was evaluated and treated by [redacted] through the home health agency (HHA) and that she was not aware if the resident received OT services as requested by the physicians on her health assessments dated on [redacted] and [redacted]. She stated that besides the HHA staff reassessment log dated from [redacted] to [redacted] the facility did not have further documentation of the specific [redacted] services extended to the resident and she did not describe further resident care extended by the facility.

In an interview with the caregiver on [redacted] at 3:50pm, she stated that she responded to resident #22's [redacted] on [redacted] immediately after she was called on by another caregiver at about 9:30pm. She stated that the resident was found on the floor in her [redacted] the resident was lying on her back with her nose and head [redacted] and

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the rolling walker was toppled over resting on or by the resident's head. She stated that the resident described that she was trying to reach for something and was not being supervised by anyone before she . She stated that she understood the resident to be independent with her ADLs, not needing direct supervision, including toileting, transferring and ambulation. She did not explain how she engaged the resident to call for facility staff assistance or how she would anticipate the resident's needs.

In an interview with resident #22's physician on at 2:15pm, he stated that the resident initially needed assistance with her ADLs in and 2014 due to her fused right knee and her previous hip replacements. He stated that the resident had an extensive medical history, including surgeries like a total knee replacement and hip replacements, and severe , which further complicated her functional status. He stated that he relied on the services to further assess the resident's functional status and he initially ordered for the patient to receive services on but did not readily have any or OT services information to ascertain the resident's complete functional status. He stated that this resident's case was of a "very debilitated woman who was significantly infirmed" and he was not aware of the specific safety precautions the facility established for the resident because he did not have anything documented representing that the facility provided him with such information.

In an interview with resident #22's physical assistant and home health agency (HHA) administrator on at 4:00pm, they stated that their HHA was responsible to deliver services for resident #22 and the resident was initially evaluated on from orders of the physician for abnormal gait , generalized muscle and functional decline. They stated that the resident initially ambulated less than 25 feet with minimal assistance using a rolling walker (RW), needed set-up assistance with , assistance with dressing to maintain her safety, minimal assistance with bathing and contact guard assistance for transfers. They stated that the resident participated in 10 sessions and that on she requested to stop services because she believed she no longer needed it. They stated that the evaluations and treatments were continually communicated to the facility nurses at the facility and the facility was given the services written reports, as attached. They stated that the resident had been instructed by services to use call bell system and to properly use her RW. They stated that on the resident's evaluation indicated that she ambulated 80 feet with contact guard assistance and that the physical did not recommend the resident to use a cane for ambulation. They stated that the physician ordered services once again on due to the resident's 2 recent the latter part of 2014. They stated that on the evaluation on the resident was capable of ambulating 25 feet, 2 times with standby assistance using the RW and needed contact guard assistance for transfers, toileting and showers. They stated that the resident had no functional range of motion on her right knee due to a and believed that she was currently in a slow progression to standby assistance/supervision with ambulation and transfer to maintain her safety. They stated that they are not aware of the facility's specific efforts to supervise the resident with her ADLs or personal care and that the facility had not discussed in totality with the HHA staff the resident's recent injuries or In an interview with the HHA administrator on at 9:45am, she stated that the HHA staff conducted resident case conferences with the facility staff, including the RCS, approximately 3 to 4 times per month and shared daily reports as needed. She stated that the written reports are handed to the facility nursing staff and the facility administrator requested the HHA to help develop a facility generalized resident safety program about a month ago, but this was not followed up on by the facility. She stated that the HHA had not received any physician order from the facility to provide OT

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910377	01/09/2015
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)		

services the resident.

Review of resident #22's hospital emergency department (ED) record dated on . indicated that she arrived to the hospital by emergency transportation due to injuries from a . while ambulating in the facility. This record indicated that the hospital instituted . prevention measures for the resident and she sustained . to her right . . . . and knee. Further review of this record indicated that her symptoms were moderate, she was prescribed pain medications and . . . . care, and was discharged from the hospital ED back to the facility. Review of the hospital ED record dated on . . . indicated that she arrived to the hospital by emergency transportation due to injuries from a . . while standing over her TRW in the facility. This record indicated that the hospital instituted . prevention measures for the resident and she sustained face, neck and scalp , closed head injury and . . . . . Further review of this record indicated that the resident had . and tenderness to her neck area, she was prescribed . . . . care and diagnostic imaging to rule out , and was discharged from the hospital ED back to the facility.

In an interview with the regional operations manager on . . . . at 2:05 pm, she stated that the facility performed investigations on the . events of residents #22, but it is not at liberty to share those investigations with the Agency, and that the facility had not filed adverse incident reports with the Agency due to the aforementioned resident . . events.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

RE: CCR #2014010051 & CCR #2014011399

Dear Administrator:

This letter reports the findings of a complaint surveys that were conducted on , 2015 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 within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review after 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

Delray Beach Field Office
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Delray Beach, FL 33484
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