STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0010 - 429.26(1&9) Fs; 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0078 - 58a-5.019(2) Fac - Staffing Standards - Staff S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0165 - 429.23(1-4 & 6-10) Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - Z815 - 408.809, 435.02(2), 435.06 - Background Screening; Prohibited Offenses S-S= C

Specific Tag Findings:

0000-Initial Comments
An unannounced Assisted Living Facility Relicensure survey was conducted on through and in conjunction with complaint # 2014011846, please refer to separate report for findings, at Villa Rio Vista. The facility had deficiencies found at the time of the visit.

An unannounced licensure complaint survey, CCR#201401184, was conducted in conjunction with this survey on the same date. Please see separate report for findings.

0010-Admissions - Continued Residency 429.26(1&9) FS; 58A-5.0181(4) FAC
Based on interview, record and observations, it was determined the facility failed to monitor the continued appropriateness of placement of a resident in the facility at all times, for 2 of 2 records reviewed (Resident #4 & # 8). As evidence of facility failure to reassess Resident #4 and #8 upon significant health and mental changes and updating the resident Health Assessment form (AHCA form 1823).

The findings:

1) Resident # 4 was admitted to the facility on A review of the AHCA form 1823 dated has a diagnosis to include and The resident requires supervision with activities of daily living, assistance with toileting care) independent with ambulating and transferring. The AHCA form 1823 dated has a diagnosis to include and Page 2 of the AHCA form 1823, section 1 regarding activities of daily living, all of page 3 regarding care tasks and general oversight, page 4 regarding whether the resident needs help taking medications and the type of assistance needed was not completed.

During an interview on at 10:50 AM with the Administrator/Owner, he was asked about any

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

Administrator
Villa Rio Vista
1115 SE 6th Terrace
Fort Lauderdale, FL 33316

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 9 through , 2015 and , 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 Davis
Field Office Manager

AMD/dso
Enclosure: 5000-3547
XG90

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

recent incidents regarding Resident #4, as she was listed in the admission discharge log as still in the facility and not on the census. It was determined Resident #4 was sent to the hospital on and has not returned. There is no evidence of documentation in the record or 24 hour report book for the reason of the transfer. The Administrator/Owner stated "the facility would have been no way of knowing" Resident #4 "called 911 due to thoughts". The last note in the record was dated The Administrator stated the resident has a history of problems and the resident has a bag because she stabbed herself with scissors.

During a telephone interview on at 10:00 AM with the Medical Director from the facility where Resident # 4 has had multiple admissions due to her ion's and multiple attempts to harm herself, he stated she has a serious schizoid and she decompensates. The facility sent her over because she was decompensating. She will at times become more "The resident requires additional/constant supervision". The medical director confirmed the resident was admitted twice under the on and after being sent to the hospital by the facility for evaluation.

A review of the notes from the most recent admission to the hospital on documents Resident #4 " presented with with plan and intention. Patient had a bag in the past after a attempt when she stabbed herself with scissors."
During a telephone interview on at 10:50 AM with the Resident #4 ' s current psychiatrist he stated he started seeing the resident around 2014 and after reviewing the information it sounds like she has chronic thoughts and a fact team may be appropriate because she needs more than monthly visits. Past behaviors include the resident taking a full bottle of and over periods of time doing harmful things that are chronic, repetitive and attention seeking.

Further observations revealed Resident #4 returned to the facility on approximately 2 PM from the facility. It was noted upon the resident's return there was no documentation of any assessment completed by the facility to ensure the resident met the criteria for continued residency and that the facility could met the resident's current care needs (including supervision).

During an interview on at 1:30 PM, it was acknowledge by the Administrator/Owner that Resident #4 requires additional supervision after multiple attempts to harm her at the facility. There is no evidence of documentation the facility implemented any interventions to ensure they can meet her care needs or completed an assessment regarding how they will continue to supervise the resident after her release from the hospital.

2) Review of Resident #8's file revealed an admission date to the facility of The most recent Resident Health Assessment form (AHCA form 1823) dated documents diagnosis as severe , gait instability, history of right hip surgery for , macrocytosis, deficient. Nursing services, special precautions documented as severe deafness, currently

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

under hospice services. The form documents the resident Activities of Daily Living (ADLs) as total with ambulation, bathing, dressing, and toileting and assistance with eating and transfer.

A review of the Facility's progress notes dated at 8:00A//M reveal an entry stating that Resident #8 was transported to the hospital after the 11-7AM staff checked on him , when she went to give Resident #8 ' s his medications. She stated when she arrived to the #8 was sitting on the floor, unable to tell what happened.

A review of the facility ' s 24 hour report log revealed no incident report or adverse incident report filed for Resident #8's on . In an interview with the Administrator and the facility nurse on at 2:29 PM, they reviewed the facility' s 24 hour reports and Resident #8 ' s record , and they confirmed there was no incident report or adverse incident filed with the agency.

A review of the hospice interdisciplinary note addendum for appropriateness evaluation dated reveals an entry that the resident had been living at the assisted living facility (ALF) for about 1 year, resident at the ALF went to the hospital where he had right hip replacement surgery and was transferred to a skilled nursing facility, where he could not participate in rehabilitation. Resident is bed bound. The power of attorney was contacted and he stated that he would like resident to return to the ALF, and that he spoke to the Administrator of the ALF and he stated Resident #8 could return to the ALF. The writer informed the POA that Resident #8 requires more care and the POA stated that the Administrator stated that he will be cared for with no problem.

A review of the facility ' s progress notes dated at 4:00 PM reveals that Resident #8 was admitted back to the ALF. A review of the hospice integrated plan of care dated reveals it was signed by the hospice nurse and the ALF nurse on and the facility is responsible for assisting resident with ADL ' s, dietary needs, simple treatments, medications and other contracted services per regulatory standards.

The hospice Nursing Assessment dated reveals that resident is bed bound and requires the assistance of 1 or more persons. The hospice aide request form dated reveals that resident is non-weight bearing, 2 person assist and does not get out of bed. The hospice Nursing Assessment dated reveals that resident is bed bound and requires total care with ADL ' s and requires turning in bed. The hospice Nursing Assessment dated reveals that resident is bed bound and unable to get out of bed.

In an observation conducted on at 10:35 AM and 4:00 PM, Resident #8 was observed in his in bed with no clothes on, alone, there were no lights on and the dark, there was no radio or television on, the bed rails were observed in the up position, he was asked if he was able to raise or lower the bed rails he stated he could not.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

In an interview conducted on at 4:05 PM with Resident #14, (the of Resident #8), he was asked how often does the staff check on the Resident #8. Resident #14 stated not very often.

In an interview conducted on at 4:20 PM with Staff F, she stated that Resident #8 has been in bed for the last week and has not gotten out of bed. In an interview conducted with the facility nurse on at 4:30 PM, she states that Resident #8 has not been out of bed for a week. In an interview conducted with Staff F on at 1:00 PM, she confirmed that it takes 2 persons to get Resident #8 out of bed.

In an interview conducted with the Facility nurse on at 1:22 PM, she confirmed that it takes 2 persons to get Resident #8 out of bed.

A review of the facility staffing schedule from 2014 through 2015, documents 1 staff member working the 8 PM-8 AM shift for a census of approximately 34.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, record review and interview the assisted living facility failed to limit the use of physical to half-bed rails and failed to obtain the consent of the Resident or the Residents' representative prior to the use of bed rails, for 1 out of 1 sampled residents' records reviewed (Resident #8).

The findings include:

During an observation made on at 10:35 AM, it was noted that Resident #8 was lying in bed with full side rails in the up position. During an interview conducted with Resident #8 on at 10:40 AM, he stated he was unable to raise or lower the bed rails. During an additional observation made on at 4:00 PM, it was noted that Resident #8 was lying in bed with full side rails in the up position.

A record review of Resident #8's file found that he was re-admitted on Record review found an order for rail pads for 1/2 rails dated Record review found a 1/2 bed rail discharge order dated and an order for a full bed rail. Resident 8's record lacked consent for bed rail use from the Residents' representative or the resident prior to the use of bed rails.

During an interview conducted with the Administrator on at 3:48 PM, he reviewed the file of Resident #8 and acknowledged that there was no consent available for review for the use of bed rails. He also stated that he thought that it was the responsibility of the hospice to obtain such consent.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

0078-Staffing Standards - Staff 58A-5.019(2) FAC

Based on record review and interview, the facility failed to ensure 1 out of 5 staff (Staff B) had a statement from a health care provider within 30 days of employment that the individual does not have any signs or symptoms of a communicable and also failed to ensure 2 out of 5 (Staff D and Staff E) current staff members have evidence of an annual negative exam.

The findings include:

1) Review of Staff B's personnel record, whose date of hire was , lacked documentation that the individual does not have any signs or symptoms of a communicable
2) Review of Staff D's personnel record, whose date of hire was , lacked documentation of a current exam.
3) Review of Staff E's personnel record, whose date of hire was , lacked documentation of a current exam.

During an interview conducted with the Administrator on at approximately 3:50 PM, he stated Staff B, Staff D and Staff E are current staff members at the facility; he also stated the staff is in direct contact with residents; he reviewed the files and confirmed the findings.

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC

Based on record review, interview and observation, the facility failed to provide care and services appropriate to the needs of residents accepted for admission to the facility as evidenced by lack of supervision, for 2 of 2 records reviewed (Resident #4 & 8).

The findings include:

A review of the facility's staffing schedule documents 1 staff member working the 8 PM-8 AM shift for a census of 34. A review of the facility staffing schedule from 2014 through 2015, documents 1 staff member working the 8 PM-8 AM shift for a census of approximately 34.

1) Resident # 4 was admitted to the facility on A review of the AHCA form 1823 dated has a diagnosis to include and The resident requires supervision with activities of daily living, assistance with toileting care) independent with ambulating and transferring. The AHCA form 1823 dated has a diagnosis to include and Page 2 of the AHCA form 1823, section 1 regarding activities of

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

daily living, all of page 3 regarding care tasks and general oversight, page 4 regarding whether the resident needs help taking medications and the type of assistance needed was not completed.

During an interview on _____ at 10:50 AM with the Administrator/Owner after reviewing the staffing schedule he confirmed 1 employee works from 8 PM-7 AM with the current census of 34. The Administrator was asked about any recent incidents regarding Resident #4 as she was listed in the admission discharge log as still in the facility and not on the census. It was determined at this time that Resident #4 was sent to the _____ hospital on _____ and has not returned. There is no evidence of documentation in the record or 24 hour report book for the reason of the transfer. The Administrator stated "the facility would have had no way of knowing" Resident #4 "called 911 due to _____ thoughts". The last note in the record was dated _____. The Administrator stated the resident has a history of _____ problems and the resident has a _____ bag because she stabbed herself with scissors. The Administrator stated he did not complete an adverse report and did not think he needed to notify AHCA of incident.

On _____ at approximately 10:30 AM the Administrator provided a 24 hour report for the incident on _____. The report was noted to be faxed on _____ at 14:55PM and signed by a staff member. It was a confirmed fax by the date and time on the top of the page.pg 2 of 3. One page was provided. A review with the Administrator of the 24 hour book documents on _____ 8 PM-7 AM "went to _____ found resident sitting on the toilet with a pool of _____ in the toilet and on the floor around the toilet. A pair of scissors on the counter beside her. I ask her what happen she told me she took the scissors from her draw and cut her down there "911 called. There was no evidence of documentation the facility completed the required incident report for Resident #4.

During a telephone interview on _____ at 10:00 AM with the Medical Director from the _____ facility where Resident # 4 has had multiple admissions due to her _____ ion's and multiple attempts to harm herself, he stated she has a serious schizoid _____ and she decompensates. The facility sent her over because she was decompensating. She will at times become more "The resident requires additional/constant supervision". The medical director confirmed the resident was admitted twice under the _____ on _____ and _____ after being sent to the hospital by the facility for evaluation.

A review of the notes from the most recent admission to the _____ hospital on _____ documents Resident #4 " presented with _____ with plan and intention. Patient had a _____ bag in the past after a _____ attempt when she stabbed herself with scissors."
During a telephone interview on _____ at 10:50 AM with the Resident #4 ' s current psychiatrist he stated he started seeing the resident around _____ 2014 and after reviewing the information it sounds like she has chronic thoughts and a fact team may be appropriate because she needs more than monthly visits. Past behaviors include the resident taking a full bottle of _____ and over periods of time doing harmful things that are chronic, repetitive and attention seeking.

2) Review of Resident #8's file revealed an admission date to the facility of _____. The most recent Resident Health Assessment form (AHCA form 1823) dated _____ documents diagnosis as severe

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

gait instability, history of right hip surgery for , macrocytosis, deficient. Nursing services, special precautions documented as severe deafness, currently under hospice services. The form documents the resident Activities of Daily Living (ADLs) as total with ambulation, bathing, dressing, and toileting and assistance with eating and transfer.

A review of the Facility ' s progress notes dated at 8:00A//M reveal an entry stating that Resident #8 was transported to the hospital after the 11-7AM staff checked on him , when she went to give Resident #8 ' s his medications. She stated when she arrived to the #8 was sitting on the floor, unable to tell what happened.

A review of the facility' s 24 hour report log revealed no incident report or adverse incident report filed for Resident #8 ' s on . In an interview with the Administrator and the facility nurse on at 2:29 PM, they reviewed the facility' s 24 hour reports and Resident #8 ' s record , and they confirmed there was no incident report or adverse incident filed with the agency.

A review of the hospice interdisciplinary note addendum for appropriateness evaluation dated reveals an entry that the resident had been living at the assisted living facility (ALF) for about 1 year, resident at the ALF went to the hospital where he had right hip replacement surgery and was transferred to a skilled nursing facility, where he could not participate in rehabilitation. Resident is bed bound. The power of attorney was contacted and he stated that he would like resident to return to the ALF, and that he spoke to the Administrator of the ALF and he stated Resident #8 could return to the ALF. The writer informed the POA that Resident #8 requires more care and the POA stated that the Administrator stated that he will be cared for with no problem.

A review of the facility ' s progress notes dated at 4:00 PM reveals that Resident #8 was admitted back to the ALF. A review of the hospice integrated plan of care dated reveals it was signed by the hospice nurse and the ALF nurse on and the facility is responsible for assisting resident with ADL ' s, dietary needs, simple treatments, medications and other contracted services per regulatory standards.

The hospice Nursing Assessment dated reveals the resident is bed bound and requires the assistance of 1 or more persons. The hospice aide request form dated reveals that resident is non-weight bearing, 2 person assist and does not get out of bed. The hospice Nursing Assessment dated reveals that the resident is bed bound and requires total care with ADL ' s and requires turning in bed. The hospice Nursing Assessment dated reveals that resident is bed bound and unable to get out of bed.

In an observation conducted on at 10:35 AM and 4:00 PM, Resident #8 was observed in his in bed with no clothes on, alone, there were no lights on and the dark, there was no

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

radio or television on, the bed rails were observed in the up position, he was asked if he was able to raise or lower the bed rails he stated he could not.

In an interview conducted on [redacted] at 4:05 PM with Resident #14, (the [redacted] of Resident #8), he was asked how often does the staff check on the Resident #8. Resident #14 stated not very often.

In an interview conducted on [redacted] at 4:20 PM with Staff F, she stated that Resident #8 has been in bed for the last week and has not gotten out of bed. In an interview conducted with the facility nurse on [redacted] at 4:30 PM, she states that Resident #8 has not been out of bed for a week. In an interview conducted with Staff F on [redacted] at 1:00 PM, she confirmed that it takes 2 persons to get Resident #8 out of bed.

In an interview conducted with the Facility nurse on [redacted] at 1:22 PM, she confirmed that it takes 2 persons to get Resident #8 out of bed.

Further review of the facility's 24 hour report book documents 18 resident incidents on the 8 PM-7 AM shift from [redacted]. During a review of the book on [redacted] at 11:30 AM with the Administrator/Owner he acknowledged some of the facility's incidents are not documented in the book and confirmed the facility could use more staff on the evening shift.
It has been acknowledge by the Administrator/Owner that Resident #4 requires additional supervision after multiple attempts to harm her at the facility. There is no evidence of documentation they facility implemented any interventions or completed an assessment regarding how they will continue to supervise the resident after her release from the [redacted] hospital.

Refer to A 0010

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review ,observations and interview, the facility failed to ensure that all direct care staff members received the required in-service trainings within 30 days of employment, for 2 out of 5 sampled employees' records reviewed (Staff A and Staff B) .

The Findings Include:

1) Review of Staff A's (hire date [redacted] personnel file revealed the record lacked documentation indicating the employee received the required 1 hour in-service trainings covering :
a) Major/Adverse Incidents and Emergency procedures
b) Recognizing/Reporting [redacted] Neglect and [redacted]
c) Elopement

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

2) Review of Staff B's (hire date personnel file revealed the record lacked documentation indicating the employee received the required 1 hour in-service trainings covering :
a) Resident Rights
b) Recognizing/Reporting , Neglect and

During an interview conducted on 11:00 AM with the facility's nurse, she identified Staff A and Staff B as direct care staff, providing personal care to the residents.
In observations conducted on from 9 AM to 2:00 PM Staff A was observed assisting residents with ambulation, transfers and assisting them to the

During an interview conducted with Staff B on at 2;00 , she stated she assists the residents in showering, dressing, making their beds, changing them and providing personal care.

In an interview conducted with the Administrator on at approximately 3:50 PM, he stated that Staff A and Staff B provide personal care to the residents; he reviewed the record and acknowledged the findings.

Class III

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

Based on record review, observation and interview, the assisted living facility failed to ensure that 2 out of 5 (staff A and B) current staff members have the required training within 30 days of employment.

Findings include:

Record review of Staff A's personnel record, whose date of hire was , lacked any documentation that Staff A completed training. Record review revealed Staff A did not complete the CORE requirement.

Record review of Staff B's personnel record, whose date of hire was lacked any documentation that Staff B completed training. Record review revealed Staff B did not complete the CORE requirement.

During an interview conducted on 11:00 AM with the facility's nurse, she identified Staff A and Staff B as direct care staff, providing personal care to the residents.
In observations conducted on from 9 AM to 2:00 PM, Staff A was observed assisting residents with ambulation, transfers and toileting. During an interview conducted with staff B on at 2:00 PM, she stated she assists the residents in showering, dressing, making their beds, changing them and providing personal care.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

During an interview with the Administrator on [redacted] at approximately 3:50 PM, he stated that Staff A and Staff B provide personal care to the residents; he reviewed the record and acknowledged the findings.

Class III

0165-Risk Mgmt. & QA; Adverse Incident Report 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC
Based on record review and interview, the facility failed to maintain and file an adverse incident report to the agency, for 2 of 2 (Resident' s#4 and #8) records reviewed, for residents that required transfer to a unit providing more acute care due to an incident at the facility.

The findings include:

A review of the Facility ' s progress notes dated [redacted] at 8:00 AM reveals an entry stating that Resident #8 was transported to the hospital after the 11-7 AM staff checked on him , when she went to give Resident #8 ' s [redacted] his medications. She stated when she arrived to the [redacted] #8 was sitting on the floor, unable to tell what happened.

A review of the Facility ' s progress notes dated [redacted] at 1:00 PM reveals an entry stating that Resident #8 was admitted to the hospital , due to a [redacted] right [redacted] and is scheduled for surgery tomorrow.
A review of the Facility ' s progress notes dated [redacted] at 12:00 PM reveals an entry stating Resident #8 had surgery yesterday. A review of the facility' s 24 hour report log revealed no incident report or adverse incident report filed to the Agency for Resident #8 ' s [redacted] and subsequent transfer to the hospital on [redacted]

During an interview with the Administrator and the facility nurse on [redacted] at 2:29 PM, they reviewed the facility' s 24 hour reports and Resident #8 ' s record , and they confirmed there was no incident report or adverse incident filed with the agency.

Class III

Z815-Background Screening; Prohibited Offenses 408.809, 435.02(2), 435.06

Based on observations, record review and interview the facility failed to ensure that a Level II Background Screening was obtained as required in 2 of 5 staff (Staff B and Staff E) records reviewed.

The findings include:

1) Review of Staff B's (hire date [redacted] personnel file revealed a background screening dated

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932401	03/05/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Villa Rio Vista	1115 Se 6th Terrace Fort Lauderdale, FL 33316	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

which stated "under review by AHCA". The AHCA Background Screening Data base was searched on at 3:45 PM and the message received was "a new screening required".

During an interview conducted on 11:00 AM with the facility's nurse, she identified Staff B as a direct care staff, providing personal care to the residents. In an interview conducted with Staff B on at 2:00 PM, she stated she assists the residents in showering, dressing, making their beds, changing them and providing personal care.

2) Review of Staff E's (hire date personnel file revealed the record contained a Level 1 background screening dated In observations conducted on and from 9:00 AM to 4:00 PM, Staff E was observed interacting with residents in the dining providing food service to the residents. The AHCA Background Screening Data base was searched on at 3:45 PM and the message received was "a new screening required".

In an interview with the Administrator on at approximately 3:50 PM, he stated that Staff B provides personal care to the residents, and Staff E provides dietary needs to the residents, he reviewed the record and acknowledged the findings.

Unclassified