STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968466	03/28/2016
NAME OF PROVIDER OR SUPPLIER **GRAND VILLA OF DELRAY WEST**	STREET ADDRESS, CITY, STATE, ZIP CODE **5859 HERITAGE PKWY** **DELRAY BEACH, FL 33484**	

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

0000 Initial Comments

An unannounced licensure complaint survey, CCR# 2016002831 was conducted on - at Grand Villa of Delray West. The facility had deficiencies found at the time of the visit.

0007 Admissions - Criteria

Based on interview and record review, the facility failed to meet the minimum criteria to admit 1 out of 1 resident (resident #1).

The findings are:

In an interview with the administrator on - at 10:45am, he stated that resident #1 was admitted to the facility on - and the resident in the memory care unit (MCU) a few hours after he was admitted to the facility.

In an interview with the administrator on - at 12:30pm, he stated that resident #1 was admitted to the facility and received a "little cut" on his head after he on - -. He stated that the resident was transported to hospital on - - around 1:00pm. He stated that he did not evaluate the resident before being admitted and he relied on the facility's (previous) memory care director and the memory care nursing supervisor to admit the resident on - -. He stated that he did not personally ensure that resident #1 met the facility's admission criteria which included the ability of the facility to meet the resident's specific needs. He stated that the facility did not ensure to receive and maintain the resident's current health assessment and was therefore not aware of the resident's clinical functional and behavioral status before admission. He stated that he was not sure if the resident was appropriate to be admitted and that he or the facility direct care staff did not know the outcome of the resident's health assessment from a current medical examination on - -.

In an interview with the memory care nursing supervisor on - at 3:15pm, she stated that she performed a nursing evaluation on resident #1 about a week before his admission on - - at his private home. She determined that the resident was a risk due to a left foot drop, to which he did not wear a device for. She stated that the resident's foot drop was due to a and not a accident. She also determined that the resident habitually got up in the middle of the night and the resident presented to be at the time. She stated that during her initial nursing assessment, she did not communicate to the resident that he was going to be admitted to the facility and she anticipated that the resident may overreact after he realized that he was going to move into the facility. She stated that she told the memory care director before resident #1 was admitted to the facility, that due to the resident's extreme risk, the resident did not meet the facility's

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

admission requirements because the facility would not be able to meet his needs. She stated that this decision must have been overruled by the facility administration since the resident was admitted on 2-18-16. She stated that when resident #1 on 2-18-16, he hit the side of his head on the wall, he broke the drywall in the MCU hallway next to the dining impact. She stated that she did not witness the resident's and was not aware if any direct care staff member was supervising the resident at the time.

In an interview with the previous memory care director on at 10:35am, she stated that she admitted resident #1 to the facility, and she relied on the memory care nursing supervisor's evaluation and an unspecified health assessment to admit this resident. She stated that the administrator did not question her decision admit resident #1 into the facility at any time. She stated that she was not aware of the date when the resident's health assessment was completed by a physician, but she remembered that the health assessment indicated that the resident needed supervision with ambulation and transfers. She stated that the resident was not previously informed that he was going to be admitted to the facility and the resident obviously overreacted on when he realized that his family left him in the facility. She stated that she was not aware of the resident's clinical behavioral status before admission. She stated that she did not witness when the resident on and was not aware if the resident was being supervised the moment before his . She stated that the resident suffered a head injury on and she did not notice any other injuries. She stated that her only concern before resident #1 was admitted on was when the memory care nursing supervisor told her that resident #1 had unsteady gait and she did not remember any further discussion with the memory care nursing supervisor regarding the resident's admission criteria and if the facility was able to meet the resident's needs.

In an interview with MCU nurse 2 on at 11:10am, she stated that she was concerned that resident #1 became so combative after his wife left him in the facility on . She stated that the memory care director or the nursing supervisor did not brief her or the other MCU direct care staff members on or before regarding the admission of resident #1. She stated that she believed that resident #1 needed wheelchair instead of a walker for ambulation to keep him safer, but could not determine this because the facility did not have resident #1's health assessment available. She stated that resident #1 needed supervision during ambulation and transferring, and she was not aware if the resident was being supervised when he on .

In an interview with MCU caregiver 4 on at 12:00pm, she stated that on at around 12:30pm, she attempted to get resident #1 inside the dining he can participate in another resident's birthday celebration, but resident #1 refused and she went inside the dining . She stated that the resident immediately after this and she was not supervising resident #1 before he on , and she did not see any other staff members supervising the resident while he was in the MCU

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

hallway before he . She stated that resident #1 was extremely combative before and after he and she felt he was not appropriate due to his behavior. She stated that the resident was ambulating uncontrollably using a rolling walker and was not safe to himself or other residents. She stated that the resident was profusely after falling and hitting his head on the wall on - - .

In an interview with the administrator on - at 12:55pm, he stated that although he relied on both of his staff members, the previous memory care director and the memory care nursing supervisor, to make resident #1's admission decision, he did not seek or consider the memory care nursing supervisor's recommendation before resident #1 was admitted on - - .

Review of the hospital records indicated that resident #1 was admitted to the emergency department on - - at 3:04pm with injuries on his head and left . Further review of this record indicated that the resident was discharged to the hospital's hospice unit on - - .

In an interview with resident #1's hospice physician on - at 11:20am, he stated that he provided medical care to resident #1 when the resident was admitted to hospice on - - for end of life care. He stated that when he examined the resident on - - , the resident was minimally responsive and agitated due to an acute hematoma, and on - , the resident was unresponsive and had ineffective breathing. He stated that the resident on - from what he suspected were complications of the resident's underlying condition coupled with the acute hematoma.

Class II

0025 Resident Care - Supervision

Based on observation, interview and record review, the facility failed to provide assisted living services to identified at-risk residents by not properly supervising their care and by not promoting their safety and physical well-being for 6 out of 7 sampled residents (residents #1,2,3,4, 5 and 6).
The findings include:
In an interview with the administrator on - at 10:45am, he stated that resident #1 was admitted to the facility on - - and the resident in the memory care unit (MCU) a few hours after he was admitted to the facility.

In an interview with the administrator on - at 1:00pm, he stated that it was common facility practice to document a resident with risk in the alert charting log but resident #1 was not entered into this log until after the resident suffered a on - - . He stated that the resident had abnormal gait. He stated that the facility did not have a specific risk policy and procedure in order to protect, prevent

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968466	**03/28/2016**
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SUMMARY STATEMENT OF DEFICIENCIES
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and reduce the residents' risk for and accidents. Review of the facility alert charting log dated on 2-18-16 at 1:00pm indicated that resident #1 had unsteady gait, lost his balance and , and was subsequently transported to the hospital by emergency services. Review of the facility's policies and procedures on - indicated that there were no specific procedures or interventions to address residents with or accident risks.

In an interview with the memory care nursing supervisor on - at 3:15pm, she stated that when resident #1 on - - , he hit the side of his head on the wall, he broke the drywall in the MCU hallway next to the dining impact. She stated that she did not witness the resident's and was not aware if any direct care staff member was supervising the resident at the time.

In an interview with the previous memory care director on - at 10:35am, she stated that she was not aware of the date when resident #1's health assessment was completed by a physician, but she remembered that the health assessment indicated that the resident needed supervision with ambulation and transfers. She stated that she did not witness when the resident on - - and was not aware if the resident was being supervised the moment before his . She stated that the resident suffered a head injury on - - and she did not notice any other injuries. She stated that her only concern before resident #1 was admitted on - - was when the memory care nursing supervisor told her that resident #1 had unsteady gait and she did not remember any further discussion with the memory care nursing supervisor regarding the resident's admission criteria and if the facility was able to meet the resident's needs.

In an interview with MCU nurse 2 on - at 11:10am, she stated that she was concerned that resident #1 became so combative after his wife left him in the facility on - - . She stated that the memory care director or the nursing supervisor did not brief her or the other MCU direct care staff members on or before - - regarding the admission of resident #1. She stated that she believed that resident #1 needed wheelchair instead of a walker for ambulation to keep him safer, but could not determine this because the facility did not have resident #1's health assessment available. She stated that resident #1 needed supervision during ambulation and transferring, and she was not aware if the resident was being supervised when he on - - .

In an interview with MCU caregiver 4 on - at 12:00pm, she stated that on - - at around 12:30pm, she attempted to get resident #1 inside the dining he can participate in another resident's birthday celebration, but resident #1 refused and she went inside the dining . She stated that the resident immediately after this and she was not supervising resident #1 before he on - - , and she did not see any other staff members supervising the resident while he was in the MCU hallway before he . She stated that resident #1 was extremely combative before and after he and she felt he was not appropriate due to his behavior. She stated that the resident was ambulating

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

uncontrollably using a rolling walker and was not safe to himself or other residents. She stated that the resident was profusely after falling and hitting his head on the wall on 2-18-16.

In an interview with the administrator on 3-23-16 at 12:55pm, he stated that although he relied on both of his staff members, the previous memory care director and the memory care nursing supervisor, to make resident #1's admission decision, he did not seek or consider the memory care nursing supervisor's recommendation before resident #1 was admitted on .

Review of the hospital records indicated that resident #1 was admitted to the emergency department on at 3:04pm with injuries on his head and left . Further review of this record indicated that the resident was discharged to the hospital's hospice unit on .

In an interview with resident #1's hospice physician on at 11:20am, he stated that he provided medical care to resident #1 when the resident was admitted to hospice on for end of life care. He stated that when he examined the resident on , the resident was minimally responsive and agitated due to an acute hematoma, and on , the resident was unresponsive and had ineffective breathing. He stated that the resident on from what he suspected were complications of the resident's underlying condition coupled with the acute hematoma.
In an observation of resident #5 on at 3:00pm, he was walking independently without any supervision or assistance in the MCU hallway next to the dining .

In an interview with the memory care nursing supervisor on at 9:40am, she stated that resident #5 ate breakfast and went to his rest. She stated that she was not aware if the resident was supervised or assisted when he went into his morning. In an observation at this time resident was resting and his shoes were placed on top of the nightstand next to his bed.

In an observation on at 12:10pm, resident #5 transferred and ambulated independently from bed to the any direct care assistance.

In an interview with caregiver 6 on at 12:15pm, she stated that she was responsible to provide direct care assistance to the facility's MCU residents and she did not assist the resident to go to the . She stated that she only assisted him to ambulate down the hallway until the resident reached the dining , and she then allowed him to walk to his own table and sit down on his own. She stated that she did not know the level of assistance the resident needed for toileting, ambulation or transfers, but she habitually allowed the resident to go to the , ambulate and transfer independently, without direct assistance.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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Review of resident #5's health assessment dated on 3-16-16 indicated that he was diagnosed with , , and . Review of this health assessment indicated that the resident had physical limitations with difficulty walking and muscle . Further review of this health assessment indicated that the resident needed direct assistance with all of his activities of daily living, including toileting, ambulation and transferring.

In an observation on - at 11:30am, resident #6 was ambulating in the MCU hallway independently without any assistive device. In an interview with MCU caregiver 5 on - at 11:35am, he stated that the resident was supposed to be using a walker to ambulate. In an interview with the MCU caregiver 5 on - at 11:45am, he stated that he did not accurately know resident #6's ambulation requirements and was informed by another caregiver that the resident did not use a walker to ambulate.

Review of resident #6's health assessment dated on - indicated that she was diagnosed with , muscle , , unspecified and . Further review of this health assessment indicated that the resident's physician ordered physical and occupational evaluations for the resident. Review of the resident's record indicated that the resident was found on the floor inside her - at 11:00pm and she suffered injuries to her head and right elbow. Further review of the resident's record indicated that her head was and she was transported to the hospital on - . Review of the hospital records dated on - indicated that the resident suffered a closed head injury and scalp laceration due to the in the facility, and was readmitted back to the facility on - .

In an interview with the memory care supervising nurse on - at 12:05pm, she stated that she was not aware of resident #6's actual physical and functional activities of daily living status because the facility did not ensure the resident received the physician ordered physical and occupational evaluations. She stated that she felt that resident #6 needed supervision with all of her activities of daily living, including ambulation and transfers. She stated that she did not complete the facility's incident investigation after the resident returned to the facility on - . She stated that a resident incident investigation must be performed immediately after a resident's incident to help determine contributors to the resident's accident or injury and interventions to prevent further accidents or injuries.

Review of resident #4's medical record indicated that he was admitted to the facility ' s memory care unit on with diagnoses including , , , s/p and right hip , , and chronic insufficiency. Review of the resident's admission health assessment dated on indicated that he required with all activities of daily living. Further review indicated the resident was alert but forgetful and required physical /occupational (/OT) services. Review of the facility internal " Resident Service Sheet " dated on indicated that the resident required supervision with ambulation and transfers and utilized a

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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walker and wheelchair. Review of the physical discharge summary dated on 9/22/2015 indicated that resident #4 was independent for bed mobility but required supervision for ambulation with a rolling walker and transfers. Resident #4 was assessed to be a risk due to his unsteadiness and and the summary indicated that the caregivers were advised to always supervise the resident when standing or walking.

Review of the current resident health assessment dated on indicated that resident #4 was independent with ambulation with an assistive device and required /OT services. Further review of the record indicated that the resident was independent for self- care, toileting and transfers. Review of the facility Resident Service Sheet dated on indicated that resident #4 was independent for ambulation, eating, , toileting and transfers. He required supervision for showers and dressing and that resident #4 ambulated with a walker.

Review of resident # 4 ' s facility incident report dated on indicated that he was found on the floor in his 3:15 AM by a care giver. The report indicated that the resident was observed to have on his right arm and lower leg and he complained of right hip pain. The report indicated that the care giver notified the physician and family and reported to the 7-3pm nursing supervisor, no additional documentation concerning any investigation of the incident was observed on the report.

Review of the facility electronic progress notes dated on at 10:30AM indicated that resident #4 had complaints of right hip pain and was unable to bear weight on his right leg. The physician was notified and an order was received for an x-ray of the right hip area. Further review indicated that the x-ray was completed at 10:45 AM and the physician was notified of the test results at 2:30PM. Resident #4 was transferred to the hospital for evaluation of a right hip at 3:30PM on / . Review of the facility incident report log sheet for 2016 indicated no documentation of resident #4 ' s or hospitalization.

Review of resident #4's hospital emergency department (ED) record dated on indicated that he arrived to the hospital by emergency transportation due to injuries from an unwitnessed while he was attempting to ambulate to the toilet at the facility. This record indicated that resident #4 had sustained a right , , femur , he was documented to have moderate pain on admission and had no memory of the . The hospital record indicated that resident #4 was assessed to be a risk and he was placed on the hospital ' s prevention program.

In an interview with the caregiver on at 10:45 AM she stated that resident #4 was independent with ambulation with a rolling walker. She stated that the resident ambulated on his own throughout the memory care unit and he required no physical support or direction while ambulating.

In an interview with the memory care nursing supervisor on at 11:50pm, she stated that she understood that resident #4 was independent with ambulation, transfers, toileting and and he required supervision with bathing and dressing. She stated that resident #4 had received services briefly after his admission but she was unable to provide any documentation of the evaluation or services which had been provided. She stated that the resident had a past history of a with right hip but he had not been assessed to be a risk and no interventions had been implemented to

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968466	**03/28/2016**
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SUMMARY STATEMENT OF DEFICIENCIES
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reduce or prevent future accidents or for the resident. The nurse reviewed the resident ' s current 1823 Health Assessment form dated on 3/8/2016 which indicated " /OT service " requirements and she stated that she had not been in communication with the health care provider/ physician to discuss services for the resident. She stated that based on her nursing judgement, the resident should be considered a risk and his ADL care levels reevaluated. The nurse stated that she had not been in communication with the hospital to determine resident 4 ' s condition and the potential readmission timeframe. She stated that she had not completed the incident investigation and had not made any determination of potential interventions to reduce resident #4 ' s risk upon his readmission.
In an interview with resident #4's physician on at 1:50PM, he stated that the resident may have been assessed to be independent with ambulation and transfers but should be monitored within the unit. He stated that the healthcare provider who had completed resident #4 ' s assessment on was employed by his office. The physician stated that if the health care provider had documented the requirement for /OT services then the facility should have notified him and the evaluation orders obtained. He stated that he relied on the evaluation to further assess the resident #4's current functional status and felt the services would benefit the resident. He stated that he reviewed his electronic medical records and did not locate any documentation that the facility had contacted him for orders and he was not aware of any safety precautions the facility had established for the resident. He stated that resident #4 had been admitted to the memory care unit based on his medical diagnoses and requirement for supervision and oversight.
In multiple observations conducted on thru , resident # 2 was observed to ambulate with her rolling walker throughout the memory care unit with no supervision by staff. The resident was observed to have an area of greenish/ purple on her right forehead and under her right eye. The resident was alert to name only and when questioned about her injury she stated that she had .
Review of resident # 2 ' s record indicated that she was admitted to the facility ' s memory care unit during with diagnoses including and . Review of the resident 2's current health assessment dated on indicated that she was independent for ambulation and transfers and she needed standby assistance with bathing, dressing, , and toileting. Review of the facility internal Resident Service Sheet dated on indicated that resident #2 was stable using the walker but required verbal reminders to use her walker.
Review of resident #2 ' s facility incident report dated on indicated that she had screamed for help and was found on the floor in an activity area at 1:15 AM, a hematoma was observed on her right forehead. Resident #2 was transported to the hospital for further evaluation and the medical physician and family were notified of the incident. Review of the facility electronic record indicated the resident returned to the facility that same day. Further review of the facility incident report indicated an investigation was conducted on , which included documented interventions to be implemented for the resident as " Resident on " and staff interventions to include monitoring. Further review of the electronic record notes indicated the resident#2 continued to ambulate with the rolling walker throughout the unit with no difficulty and staff reminded the resident to utilize her walker.

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SUMMARY STATEMENT OF DEFICIENCIES
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Further review of resident #2 ' s medical record indicated no additional contact with the physician after the initial notification and no request for reassessment of the resident as a risk, no orders for physical evaluation or reevaluation by the nursing staff to update the resident ' s service sheet.
Review of resident #2'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 she sustained a right forehead hematoma.
In an interview with the memory care nursing supervisor on at 11:45 PM, she stated that she understood that resident #2 was mostly independent with ambulation and transfers and required supervision with bathing, dressing and toileting. She stated that the facility did not implement any demonstrable interventions to reduce or prevent future accidents or for the resident after her hospitalization. She stated that she thought resident #2 had been on services but was unable to provide any documentation of such services. She stated that she had not been in communication with the health care provider to discuss physical ( ) for the resident. She stated that resident#2 should be considered a risk and reevaluated for her ADL care. She stated that the facility policy included that after each , the resident should be reevaluated and a new Resident Service form be completed. She stated that she had not completed the form.
In an interview with the caregiver on at 10:45 AM she stated that resident #2 was independent with ambulation with a rolling walker. She stated that the resident had recently and should be monitored more frequently by all staff. She stated that the resident wanders through out the unit on her own. She stated that unit did not utilize any personalized call bell system due to the resident ' s limitations, so staff were responsible to monitor the residents for .
In an interview with resident #2's physician on at 1:50PM, he stated that the resident may have been assessed to be independent with ambulation and transfers but should be monitored within the unit and be reevaluated with services provided as a result of the . He stated that he relied on the evaluation to further assess the resident #2's functional status and felt the services would benefit the resident. He stated that he reviewed his electronic medical records and could not locate have any documentation that the facility had contacted him for orders and he was not aware of any safety precautions the facility had established for the resident after her .
Review of resident #3 ' s record indicated that he was admitted to the facility ' s memory care unit on with diagnoses including , , , , , chronic kidney and prostatic hyperplasia. Review of resident#3's admission health assessment dated on indicated that he required with all activities of daily living, including 2-person assistance with transfer, bathing, dressing and toileting. Further review indicated resident #3 was oriented to person only and could follow simple commands. The assessment indicated the resident had progressive loss and muscle strength becoming weaker in gait performance. Review of the facility internal " Pre move-in " Resident Service sheet dated on indicated resident #3 required supervision with ambulation and transfers and utilized a walker. Further review of the facility internal Resident Service sheet indicated that resident #3 required assistance for showers, dressing,

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

grooming and toileting. The form indicated the resident needed /OT evaluation for admission.
In multiple observations conducted on 3/22/2016 thru 3/23/2016, resident #3 was observed sitting in his wheelchair participating in activity programs and in the dining his meals. Resident #3 was observed to make attempts to move his wheelchair by himself and stand up on his own. Staff were observed to provide verbal cueing for the resident to remain seated in his wheelchair.
Review of resident #3 ' s facility incident report dated on indicated that he was found on the floor in his 6:00 AM by a care giver. The resident was observed to have on both arms and no other observed injuries. The report was completed by the care giver who had notified the day shift nursing supervisor of the incident. Further review of the report indicated no additional documentation concerning the investigation of the incident had been completed.
In an interview with the caregiver on at 10:45 AM she stated that resident #3 required staff assistance for his activities of daily living (ADL). She stated resident #3 was unable to ambulate and could only able to take 1-2 steps for transfers. She stated that the resident used a wheelchair for mobility and staff were to monitor him at all times since he had made attempts to stand by himself. She stated that she was not sure if he had sustained any since his admission or if he was considered a risk. She stated that she would be verbally notified by the nursing supervisor when a resident was considered a risk. She stated that she was not sure what other specific interventions would be implemented if a resident was identified as a risk, only to monitor the resident.
In an interview with the memory care nursing supervisor on at 11:50pm, she stated that she understood that resident #3 required for his ADL care. She stated that he was unsteady while standing and required 1-2 staff for transfers and he was utilized a wheelchair for mobility. She stated that she had reviewed the Resident Service sheet prior to resident #3 ' s admission and felt the resident had a very high potential as a risk and he would require additional supervision by the staff to reduce his risk. The nurse reviewed the resident ' s current 1823 Health Assessment form dated on which indicated no risk indication, and no nursing or requirements for the resident. She stated that she had not been in communication with the health care provider/ physician to discuss a evaluation/services for the resident. She stated that resident #3 had been found on the floor in his at 6 AM.
Class II

0165 Risk Mgmt & QA: Adverse Incident Report

Based on observation, interview and record review, the facility failed to notify the agency of multiple incidents, including preventable , that required 2 of 7 sampled residents (Resident #1 and #4) to be transferred to a facility providing a higher level of care.
The findings include:
In an interview with the administrator on - at 12:30pm, he stated that resident #1 was admitted to the facility and received a "little cut" on his head after he on - - . He stated that the resident was

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	AL11968466	**03/28/2016**
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SUMMARY STATEMENT OF DEFICIENCIES
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transported to hospital on 2-18-16 around 1:00pm. He stated that he did not evaluate the resident before being admitted and he relied on the facility's (previous) memory care director and the memory care nursing supervisor to admit the resident on 2-18-16. He stated that he did not personally ensure that resident #1 met the facility's admission criteria which included the ability of the facility to meet the resident's specific needs. He stated that the facility did not ensure to receive and maintain the resident's current health assessment and was therefore not aware of the resident's clinical functional and behavioral status before admission. He stated that he was not sure if the resident was appropriate to be admitted and that he or the facility direct care staff did not know the outcome of the resident's health assessment from a current medical examination on - - .

In an interview with the memory care nursing supervisor on - at 3:15pm, she stated that she performed a nursing evaluation on resident #1 about a week before his admission on - - at his private home. She determined that the resident was a risk due to a left foot drop, to which he did not wear a device for. She stated that the resident's foot drop was due to a and not a accident. She also determined that the resident habitually got up in the middle of the night and the resident presented to be at the time. She stated that during her initial nursing assessment, she did not communicate to the resident that he was going to be admitted to the facility and she anticipated that the resident may overreact after he realized that he was going to move into the facility. She stated that she told the memory care director before resident #1 was admitted to the facility, that due to the resident's extreme risk, the resident did not meet the facility's admission requirements because the facility would not be able to meet his needs. She stated that this decision must have been overruled by the facility administration since the resident was admitted on - - . She stated that when resident #1 on - - , he hit the side of his head on the wall, he broke the drywall in the MCU hallway next to the dining impact. She stated that she did not witness the resident's and was not aware if any direct care staff member was supervising the resident at the time.

In an interview with the previous memory care director on - at 10:35am, she stated that she admitted resident #1 to the facility, and she relied on the memory care nursing supervisor's evaluation and an unspecified health assessment to admit this resident. She stated that the administrator did not question her decision admit resident #1 into the facility at any time. She stated that she was not aware of the date when the resident's health assessment was completed by a physician, but she remembered that the health assessment indicated that the resident needed supervision with ambulation and transfers. She stated that the resident was not previously informed that he was going to be admitted to the facility and the resident obviously overreacted on - - when he realized that his family left him in the facility. She stated that she was not aware of the resident's clinical behavioral status before admission. She stated that she did not witness when the resident on - - and was not aware if the resident was being supervised the moment before his . She stated that the resident suffered a

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	AL11968466	03/28/2016
NAME OF PROVIDER OR SUPPLIER **GRAND VILLA OF DELRAY WEST**	STREET ADDRESS, CITY, STATE, ZIP CODE **5859 HERITAGE PKWY** **DELRAY BEACH, FL 33484**	

SUMMARY STATEMENT OF DEFICIENCIES
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head injury on 2-18-16 and she did not notice any other injuries. She stated that her only concern before resident #1 was admitted on 2-18-16 was when the memory care nursing supervisor told her that resident #1 had unsteady gait and she did not remember any further discussion with the memory care nursing supervisor regarding the resident's admission criteria and if the facility was able to meet the resident's needs.

In an interview with MCU nurse 2 on - at 11:10am, she stated that she was concerned that resident #1 became so combative after his wife left him in the facility on - -. She stated that the memory care director or the nursing supervisor did not brief her or the other MCU direct care staff members on or before - - regarding the admission of resident #1. She stated that she believed that resident #1 needed wheelchair instead of a walker for ambulation to keep him safer, but could not determine this because the facility did not have resident #1's health assessment available. She stated that resident #1 needed supervision during ambulation and transferring, and she was not aware if the resident was being supervised when he on - -.

In an interview with MCU caregiver 4 on - at 12:00pm, she stated that on - - at around 12:30pm, she attempted to get resident #1 inside the dining he can participate in another resident's birthday celebration, but resident #1 refused and she went inside the dining . She stated that the resident immediately after this and she was not supervising resident #1 before he on - -, and she did not see any other staff members supervising the resident while he was in the MCU hallway before he . She stated that resident #1 was extremely combative before and after he and she felt he was not appropriate due to his behavior. She stated that the resident was ambulating uncontrollably using a rolling walker and was not safe to himself or other residents. She stated that the resident was profusely after falling and hitting his head on the wall on - -.

In an interview with the administrator on - at 12:55pm, he stated that although he relied on both of his staff members, the previous memory care director and the memory care nursing supervisor, to make resident #1's admission decision, he did not seek or consider the memory care nursing supervisor's recommendation before resident #1 was admitted on - -.

Review of the hospital records indicated that resident #1 was admitted to the emergency department on - - at 3:04pm with injuries on his head and left . Further review of this record indicated that the resident was discharged to the hospital's hospice unit on - -.

In an interview with resident #1's hospice physician on - at 11:20am, he stated that he provided medical care to resident #1 when the resident was admitted to hospice on - - for end of life care. He stated that when he examined the resident on - -, the resident was minimally responsive and agitated due to an acute hematoma, and on -, the resident was unresponsive and had

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ineffective breathing. He stated that the resident on 2-22-16 from what he suspected were complications of the resident's underlying condition coupled with the acute hematoma.

In an interview with the administrator on 3-23-16 at 1:05pm, he stated that the facility did not file any adverse incident report for the involving resident #1 on - - , which led to the hospitalization of the resident. He stated that he understood that the he did not consider every aspect of the resident's care needs which may have prevented him from having admitted the resident into the facility.

Review of resident #4 ' s medical record indicated that he was admitted to the facility ' s memory care unit on with diagnoses including , , , s/p and right hip , , and chronic insufficiency. Review of the resident health assessment dated on indicated that resident #4 was independent with ambulation utilizing an assistive device and required /OT services. Review of the facility internal " Resident Service Sheet " dated on indicated that the resident required supervision with ambulation and transfers and utilized a walker and wheelchair. Review of a physical discharge summary dated on indicated that resident #4 was independent for bed mobility but required supervision for ambulation with a rolling walker and transfers. Resident #4 was assessed to be a risk due to his unsteadiness and and the summary indicated that the caregivers were advised to always supervise the resident when standing or walking. . Review of the facility Resident Service Sheet dated on indicated that resident #4 was independent for ambulation, toileting and transfers and supervision for showers and dressing.

Review of resident # 4 ' s facility incident report dated on indicated that he was found on the floor in his 3:15 AM by a care giver. The report indicated that the resident was observed to have on his right arm and lower leg and he complained of right hip pain. Further review of the report indicated that the care giver notified the physician and family and reported to the 7-PM nursing supervisor, no additional documentation concerning any investigation of the incident was observed on the report. Review of the facility electronic progress notes dated on at 10:30AM indicated that resident #4 had complaints of right hip pain and was unable to bear weight on his right leg. The physician was notified and an order was received for an x-ray of the right hip area. Further review indicated that the x-ray was completed at 10:45 AM and the physician was notified of the test results at 2:30 PM. Resident #4 was transferred to the hospital for evaluation of a right hip at 3:30 PM on . Review of the facility incident report log sheet for 2016 indicated no documentation of resident #4 ' s or hospitalization.

In an interview with the memory care nursing supervisor on at 11:50 PM, she stated that resident #4 had a history of but was independent for ambulation, and not identified as a risk. She stated resident #4 was found on the floor in his the night on . She stated that X-rays were completed and the results indicated that the resident #4 had his right hip and he was sent to the emergency treatment.

Review of resident #4's hospital emergency department (ED) record dated on indicated that

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he arrived to the hospital by emergency transportation due to injuries from an unwitnessed , while he was attempting to ambulate to the toilet at the facility. This record indicated that resident #4 had sustained a right , , femur , he was documented to have moderate pain on admission and had no memory of the . The hospital record indicated that resident #4 was assessed to be a risk and he was placed on the hospital ' s prevention program.
In an interview with the Executive Administrator on at 1:00 PM he stated that he he was notified that resident #4 had ,fracturing his hip which required the tranfer to a higher level of care for treatment. He stated that he had not filed a 1- day adverse incident report with the state for resident #4.
Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, , 2016

Grand Villa Delray West
5859 Heritage Park Way
Delray Beach, FL 33484-8557

Attention: Bob McAdams, Administrator

Dear Mr. McAdams,

This letter reports finding of a complaint investigation conducted from - to - - by representatives of the Agency for Health Care Administration. You are directed to comply with the tangible steps outlined below in order to correct the deficient practices. Attached are the deficiencies noted in the investigation.

The investigation resulted in findings of noncompliance with the following areas:

A7- Resident Admission Criteria - Class II - The facility failed to ensure that residents met admission criteria and that the facility could meet the residents' needs upon admission. This was evidenced by the facility's failure to ensure a resident was determined to be safe to himself or others by a physician or a licensed mental health provider.

A 25 - Resident Care-Supervision - Class II - The facility failed to arrange the proper care and services to meet the needs of the residents. This was evidenced by the facility's failure to provide resident assistance or supervision with their activities of daily living (ADLs).and failure to arrange physical and occupational therapies for its residents upon receipt of a physician order.

A 165 - Class III - The facility failed to report every potential adverse incident to the Agency. This was evidenced by the facility's failure to report events which required the residents to be transferred to the hospital after suffering injuries in the facility which may have been prevented.

Your facility must comply with the following:

1. The facility is required to develop a comprehensive policy and procedure for monitoring the care and safety needs of all residents in the facility, with consideration of each resident's functional ability, physical/sensory limitations, /behavioral status, supplemental service requirements and special precautions, including but not limited to

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prevention, based on their health assessment. This must be completed by

2. Any resident identified by any direct care staff member to have functional abilities, physical/sensory limitations and /behavioral status inconsistent with their current health assessment or needing supplemental services and special precautions not identified in their current health assessment, must immediately be referred to undergo a physician/physician extender examination for determination of the resident's current needs. This process must be implemented upon receipt of this DPOC.

3. This care and service policy and procedure must include maintenance of an up-to-date log identifying residents with special precautions, the facility staff person(s) responsible to deliver or supervise the care and service, and the type and frequency of care and service each resident is to receive based on their health assessment. This must be completed by .

4. The facility is required to develop a written comprehensive policy and procedure for immediately evaluating the care and safety needs of residents having suffered a /accident or suspected to have / had an accident. This must be completed by . This post /accident policy and procedure must include a facility licensed nurse(s) responsible to deliver proper care and service to identified resident, including but not limited to immediate resident referrals to a higher level of care, determination of a resident significant change, determination of a potential adverse event and other resident-centered measures to prevent future similar events. This must be completed by - .

5. This post /accident policy and procedure must include a facility licensed nurse responsible to assess each resident upon readmission to the facility from a hospital, nursing home or any other health facility, within 3 days. The facility registered nurse must use this readmission assessment to compare with the resident's previous health assessment and with details from previous /accident event(s) which precipitated the resident's discharge from the facility. The facility licensed nurse must consult with the administrator within 2 days after the readmission assessment and determine that the readmitted resident's current condition meets the facility's ability to deliver adequate and proper care and service to this resident. This must be completed by - .

6. The assisted living facility must develop and implement a policy and procedure which evaluates each and every resident event which involves resident injury immediately. Additionally, it will be required that the administrator make a decision to determine whether each of these events may have been prevented by the facility within 24 hours and the facility must report to the Agency any potential adverse incident within 24 hours. All direct care staff of the facility must be trained on the facility's adverse incident reporting policy. This must be completed by .

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

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Tallahassee, FL 32308
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Should you have any questions, please contact Laura Manville, Assisted Living Enforcement Team Manager at 727-552-1955 or Tikle Wedges-Phoenix, Assistant Living Supervisor at 561-381-5840.

Sincerely,

Arlene Maya-Davis
Field Office Manager

D7JR

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