STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	03/17/2016
NAME OF PROVIDER OR SUPPLIER VICTORIA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 5151 S.W. 61 AVENUE DAVIE, FL 33314	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted on 3/17/16 and / at Victoria Villa. The facility had deficiencies at the time of the visit.

0008 Admissions - Health Assessment

Based on record review and interview, the facility failed to ensure an updated health assessment (ACHA Form 1823) for 1 of 2 residents, whose records were reviewed, was completed in its entirety (Resident #1).
The findings include:
During review of Resident #1's current, updated health assessment (AHCA Form 1823), it was noted Section 1, Part D, did not indicate whether this resident's individual needs could be met in an assisted living facility.
It was also noted that Section 3, which specifies the services offered or arranged by the facility, was not signed by Resident#1's Guardian or Designee. It was also not indicated as to whether this form would be used for Medicaid Assessment for Assistive Care Services.
During interview with Administrator on at 1:25 PM, the administrator acknowledged the missing documentation on the health assessment.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation, interview and record review, it was determined the facility failed to provide appropriate health care consistent with established and recognized standards within the community; specifically related to failure to wash hands during the provision of medications, for 5 of 6 sampled residents (Residents #13, #20, #23, #24, and #25) and for failure to clean medical equipment per recognized community standards, specifically related to a pill crusher and glucometer. It was also determined the facility failed to provide each resident with due recognition of personal dignity and the need for privacy. Based on additional observations and interview, it was also determined the facility failed to ensure that all advocacy numbers were prominently posted in the facility and that residents had convenient access to a telephone to facilitate the resident's right to unrestricted and private communication.

The Findings included:

1) Review of the facility's policy and procedure related to Control indicated it is the policy of

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	03/17/2016
NAME OF PROVIDER OR SUPPLIER **VICTORIA VILLA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5151 S.W. 61 AVENUE** **DAVIE, FL 33314**	

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

this facility to protect residents and employees from exposure to any material. This policy reflects that all staff will wash hands after each resident contact and immediately after removing protective gloves.

During medication observation of Staff A (LPN - Licensed Practical Nurse), conducted on from approximately 8:45 AM - 9:30 AM, she provided oral medication; eye drops (gloves were utilized), and a , patch (gloves were utilized) to 5 different residents without washing or sanitizing her hands at any time during this 45 minute observation. During interview with the Administrator, conducted on beginning at approximately 1:20 PM, she acknowledged that the failure to wash hands between resident contact was not an acceptable practice.

2) During medication observation of Staff A (LPN), conducted on beginning at 9:40 AM, she was asked about the condition of the pill crusher. It was noted to be heavily encrusted with debris (a picture was taken of this pill crusher). Staff A stated it was her personal pill crusher. She was asked if it is used to crush any medications for the residents of this facility. She acknowledged that it was. She was asked when the last time it was cleaned. She could not provide an answer.

3) During dining observation conducted at the Cottage, on beginning at approximately 12:08 PM, Staff J (DCS - Direct Care Staff) was observed standing at the corner of a table at which 2 residents were seated. Staff J was noted to stand between these two residents and feed them. She would provide one resident with a bite or two of food and then the other resident with a bite or two of food. She would wipe their mouths between several bites. (These two residents were not able to feed or even assist with feeding themselves). This staff member was not observed to wash or sanitize her hands before, during, or after this meal service. She was also noted to have been standing the entire time between these two residents, instead of sitting in a chair beside them, therefore, making this a more dignified experience.

4) During medication observation of Staff A (LPN - Licensed Practical Nurse), conducted on from approximately 8:45 AM - 9:30 AM, she provided oral medication; eye drops, and a patch to 5 different residents. Staff A left the MOR binder open to each resident's MOR (Medication Observation Record) when she would leave the medication cart to provide each resident with their medications. She did not close the binder or cover the MOR to protect each resident's right to privacy in this dining .

5) A brief observational tour was conducted with the Supervisor of the facility on beginning at approximately 10:00 AM. She was asked for the location of the required agency advocacy telephone numbers. She could not locate the agency's complaint hotline or the Rights Florida Number in the main building. She was asked if these numbers were posted in the Villa or the Cottage. She stated they were not because she was not aware of the requirement to post these numbers. She was asked

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	**03/17/2016**
NAME OF PROVIDER OR SUPPLIER **VICTORIA VILLA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5151 S.W. 61 AVENUE DAVIE, FL 33314**	

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

how the facility ensures each resident's right to unrestricted and private use of a telephone. She stated if a resident needed to use a phone that they would take them into an office where they could use the phone. She was asked how a resident could make a phone call without having to ask permission to do so. She stated they do not have that ability. She was asked if there was a portable phone for residents to use that they could take to their make a private call if they chose to. She stated they do no have a portable phone for resident use. She stated all they have is wired phones in office in the main building and a wired phone in the common area of the Cottage and Villa.
6) On at 9:00 AM till / at 2:30 PM, a posting containing the names of a physcian patients, who were current residents of the facility, was posted on the outside of the nurse's station door where it was able to be read by anyone coming into the facility.

7) On at 11:00 AM, staff D begins using an electric razor to shave a male resident while he is sitting in a chair participating in group activities.
At 11:13 AM, staff C removes another electric razor out of a wicker bin located along the wall in the activity begins to shave a second male resident who is also sitting in chair participating in group activities. When finished, she cleans the razor and puts it back in the bin.
At 11:18 AM, staff C removes a third electric razor from wicker bin and hands it to a 3rd male resident sitting in chair participating in group activities. This resident uses the razor and shaves himself. Staff C cleans the razor and returns it to the bin.
At 11:25 AM, Staff C removes another electric shaver and shaves a 4th male resident while he is sitting in chair participating in group activites.
At no time during this interaction are the three residents who are shaved asked if they wanted to be shaved.
Interview with Staff C on at 11:30 AM reveals all electric shavers are labeled with the names of the male residents, and no razor is used on more than one resident.
During interview with Administrator on / / at 2:30 PM, she stated the staff shaved the male residents during activities because there was so many other things to do to in the mornings to get the residents up and ready for breakfast, and it saved some time to wait until later to shave them.

8) On / / at 12:40 PM, the LPN (Staff G) was observed checking the glucose level for Resident # 15 while the resident was seated at a dining , along with 3 other Residents. After the LPN discovered the glucose level was high enough to receive the sliding scale dosage of ; he prepared the syringe, stated to the resident that he was going to give him his , and proceeded to pull up the Resident's shirt sleeve and administer the injection at the dining in front of other residents, staff and visitors.

9) On at 12:20 PM, during medication administeration observation, the LPN (Staff G) was observed performing a glucose/ for Resident # 14. The LPN placed lancet into injection

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	03/17/2016
NAME OF PROVIDER OR SUPPLIER VICTORIA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 5151 S.W. 61 AVENUE DAVIE, FL 33314	

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

pen and used the injection pen to prick Resident #14's finger. The LPN placed glucose testing strip next to drop of and collected sample, which was placed in glucometer. The LPN removed the lancet from injection pen and placed in plastic cup on top of Med Cart for later disposal in sharps container. LPN then removed glucose strip from glucometer and discarded. LPN recorded reading in MOR for Resident #14.

Next, the LPN (Staff G) placed another lancet into the injection pen and approached Resident #15. He used the injection pen to prick resident's finger but it didn't work the first time. He reloaded the injection pen and pricked the finger a second time. LPN placed glucose testing strip next to drop of to collect sample, which was placed into the glucometer. The LPN removed the lancet from the injection pen and placed in plastic cup on top of Med Cart. The glucose testing strip was removed from glucometer and the reading was recorded in the MOR for Resident #15.

It was noted for each of the performed for Resident #14 and #15, the LPN failed to clean the injection pen and the glucometer, per manufacturer's instructions, after each use.

On , at 1:30 PM, after the administer was asked about manufacturer's instructions for the glucometer, the LPN was observed labeling 4 new glucometers with residents' names. When asked why only 1 glucometer was used during lunch , Staff G responded, "I only had 1 type of testing strips."

On at 1:20 PM, the Administrator was informed of the lack of of the glucometer after each use. The administrator stated that each resident had their own glucometer and one glucometer should not have been used for multiple residents.

Class III

0053 Medication - Administration

Based on observation, interview, and record review, it was determined the facility failed to ensure that medications were available to administer in accordance with a health care provider's order and that medications are provided in a form that is in accordance with a health care provider's order for 1 of 6 residents observed for medications (#22).

The findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	03/17/2016
NAME OF PROVIDER OR SUPPLIER VICTORIA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 5151 S.W. 61 AVENUE DAVIE, FL 33314	

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

During medication observation of Staff G (LPN - Licensed Practical Nurse), on / beginning at approximately 9:10 AM, he was observed to have provided Resident #22 with his oral medications. Staff G stated that Resident #22 had been provided with his by the DCS (Direct Care Staff) and he proceeded to attempt to initial that it had been provided. This surveyor asked him how he knew it had been provided. He stated because it is the responsibility of the DCS to apply the . Again, he was asked how he knew it had been provided to Resident #22. Staff G then asked Staff J (DCS) if she had provided Resident #22 with his . She replied that she had not. She was asked why by Staff G. Staff J stated she has not had the since sometime last week. She was asked by Staff G if she reported that to the nurse. She replied that she had. Review of the Medication Record for Resident #22 reflected (in the form of various nurse's initials) that the had been provided twice daily to the hands (8:00 AM and 5:00 PM) from / - in the morning. Staff G (LPN) could not provide an explanation as to why the was initialed as having been provided to Resident #22 on those dates.

2) During medication observation of Staff G (LPN - Licensed Practical Nurse), on beginning at approximately 9:10 AM, he was observed to have provided Resident #22 with his oral medications as follows:

a) 81mg daily
b) Syrup 15ml daily
c) Co Q10 200mg in the morning
d) ( ) 250mg DR in the morning
e) My-Potenza in the morning
f) Neo 40 in the morning on an empty stomach (provided prior to meal)
g) ( ) 325mg tablets (x2) twice daily
h) 20mg twice daily
i) 100mg
j) ( ) 2.5mg twice daily
k) NADH twice daily
l) Stem X Cell Pro take 2 pills at breakfast and 2 pills at lunch
m) 100mg three times daily
n) Glycocarn three times daily
o) C2 three times daily
p) GH-7 three times daily
q) Tumeric Advanced Formula three times daily
r) Pure Way 500mg three times daily
s) Carb/Levo ( ) take 1.5 pills four times daily
t) D3 5,000IU in morning

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	03/17/2016
NAME OF PROVIDER OR SUPPLIER VICTORIA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 5151 S.W. 61 AVENUE DAVIE, FL 33314	

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

All capsules were opened and contents were poured into a medication cup and then mixed with applesauce; the liquid caps were cut with scissors and contents were poured into medication cup with applesauce; the remaining pills were crushed with a pill crusher and then placed in a medication cup with applesauce; Resident #22 consumed all of his medications in this manner without any complaints. However, Staff G was asked where on the Medication Record or Medication Label did it indicate that any of these medication were to be crushed and placed in applesauce. He acknowledged that the Medication Record nor the labels indicate this but because of Resident #22's cognition he requires his medications to be crushed.

During subsequent interview with the Supervisor, on beginning at approximately 10:30 AM, she was provided the opportunity to locate any documentation that indicated this resident's medications are to be crushed. She was no able to locate this information. She acknowledged that the MR (Medication Record) did not reflect this resident's medications are to be crushed. She reviewed all "thinned" records for this resident and was still not able to locate any documentation to reflect this resident's medications are to be crushed. She was informed that if medications are being crushed for a resident that there needs to be a physician's order to do so. She acknowledged understandings. She was informed that some of the medication that were crushed were actually medications that should not be crushed (for example: the as any medications are not to be crushed). She asked if the doctor would know what medications are to be crushed or if the pharmacist would know. She was instructed to contact the doctor to see if he wanted the medications crushed. She subsequently received an order from Resident #22's physician, dated , that indicated 5 of the 20 medications that were crushed are to be crushed:

a) 2.5mg
b) 325mg
c) 10mg
d) 25mg-100
e) 2.5mg

Class III

0054 Medication - Records

Based on observation, interview, and record review, it was determined the facility failed to maintain an accurate medication observation record for each resident who receives assistance with the self-administration of medications or medication administration, for 2 of 6 sampled residents (Resident #22 and Resident #13).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	03/17/2016
NAME OF PROVIDER OR SUPPLIER **VICTORIA VILLA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5151 S.W. 61 AVENUE** **DAVIE, FL 33314**	

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

The Findings included:

1) During medication observation of Staff G (LPN - Licensed Practical Nurse), on beginning at approximately 9:10 AM, he was observed to have provided Resident #22 with his oral medications. Staff G stated that Resident #22 had been provided with his by the DCS (Direct Care Staff) and he proceeded to attempt to initial that it had been provided. This surveyor asked him how he knew it had been provided. He stated because it is the responsibility of the DCS to apply the . Again, he was asked how he knew it had been provided to Resident #22. Staff G then asked Staff J (DCS) if she had provided Resident #22 with his , . She replied that she had not. She was asked why by Staff G. Staff J stated she has not had the since sometime last week. She was asked by Staff G if she reported that to the nurse. She replied that she had. Review of the Medication Record for Resident #22 reflected (in the form of various nurse's initials) that the had been provided twice daily to the hands (8:00 AM and 5:00 PM) from / - in the morning. Staff G (LPN) could not provide an explanation as to why the was initialed as having been provided to Resident #22 on those dates.

2) During observation of Staff A (LPN), on beginning at approximately 9:17 AM, she obtained an patch 9.5mg from the box labeled for Resident #13. She applied gloves and dated the patch. She approached Resident #13 in the main dining he was having his breakfast, and she pulled his shirt open at the collar and looked down the back of his shirt for an old patch to remove. She stated it must have off. She then proceeded to apply the new patch to Resident #13's upper shoulder blade area on the right side. Review of the MOR (Medication Observation Record) did not reflect the location of where these patches are applied. The manufacturer's instructions indicate not to apply the patch in the same location for a minimum of 14 days as this could cause skin irritation. Staff A called over the Supervisor and asked her if she knew anything about documenting the rotation of the patches. The Supervisor stated she was not aware of the need to do this, but that it would make sense if these patches cannot be placed in the same located for a minimum of 14 days.

Class III

0055 Medication - Storage and Disposal

Based on observations and interviews it was determined the facility failed to ensure their medications and potentially hazardous medical supplies (used sharps) were maintained in a secure manner at all times, specifically related to the medication cart and the medication .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	03/17/2016
NAME OF PROVIDER OR SUPPLIER VICTORIA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 5151 S.W. 61 AVENUE DAVIE, FL 33314	

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

The Findings included:

1) During medication observation conducted with Staff A (a licensed practical nurse with a date of hire noted as) conducted on / beginning at approximately 9:40 AM, the medication cart that was located in the main dining left unlocked and unattended. The keys to the cart and the drawer were located on top of the medication cart and the top drawer was left slightly ajar. This surveyor took a picture of this observation and awaited for Staff A - LPN (Licensed Practical Nurse) to return to the medication cart. Upon Staff A's return (approximately 3-5 minutes later) Staff A was asked for an explanation as to why she left the medication cart unlocked with the keys on top of the cart in a dining had approximately 30 residents and several staff members coming in and out. She could not provide an explanation.

During subsequent interview conducted with the Administrator on / beginning at approximately 1:20 PM, she was informed of the medication cart being left unlocked and unattended in the main dining beginning at approximately 9:40 AM. The Administrator acknowledged that this was an unacceptable practice.

2) Upon entrance to the facility on / at 8:35 AM, the medication /nurse's station was unlocked with the door wide open. The LPN on duty was in the dining medications to residents preparing for breakfast. Her back was turned against the dining , and unable to see the entrance to the nurse's station. It is noted that all residents have / related

On at 8:35 AM, the following items are sitting in the unlocked, open and unattended nurse's station.

a) kit for Resident #3
b) 200mg (OTC/unlabeled)
c) , 5 mg, for Resident #21
d) Solution 0.05% for Resident #4
e) Ointment for Resident #5
f) Healing Ointment (OTC/unlabeled)
g) Paper bag of several different medications for Resident #6
h) Plastic bin of newly delivered medications for various residents, sitting on bottom shelf of bookcase
i)Open and accessible sharps container sitting on floor next to entrance.
j) Two 3-drawer, plastic bins filled with various OTC lotions, jelly, balmex, enemas, suppositories, nasal sprays, etc.

The door to the nurse's station remained open and unlocked the entire time of survey on / and / (8:30 AM - 2:30 PM).

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	03/17/2016
NAME OF PROVIDER OR SUPPLIER VICTORIA VILLA	STREET ADDRESS, CITY, STATE, ZIP CODE 5151 S.W. 61 AVENUE DAVIE, FL 33314	

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

During interview with the Administrator on 03/17/2016 beginning at approximately 1:20 PM, she was informed of the nurse's station being left unlocked and open during both days of the survey. She confirmed that the nurse's station door was to be kept locked at all times when the nurse was not present in the nurse's station.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, it was determined the facility failed to ensure that they provided each resident with a safe living environment, specifically related to a reclining chair that was in disrepair in the Cottage.

The Findings included:

During observational tour of the Cottage, conducted on beginning at approximately 10:35 AM, there was a brown reclining chair that contained hundreds of tiny marks on the arms and seat and the head-rest area contained a large area (measuring approximately 10" X 8") that was missing the leather/vinyl covering. Staff J confirmed that the damage was caused by one of the cats that resides at the facility. Staff J confirmed that this chair is utilized by the residents of the Cottage. During subsequent interview conducted with the Administrator, on at approximately 2:00 PM, this concern was brought to her attention. She stated that chair belongs to hospice. She was asked if the residents of the Cottage utilize it. She confirmed that they do.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Victoria Villa
5151 S.W. 61 Avenue
Davie, FL 33314

RE: Relicensure Survey

Dear Administrator:

This letter reports the findings of a state Relicensure survey that was conducted on , 2016 and , 2016 by representatives 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 representatives. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure
XG90

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