STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953473	05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA ROSE ASSISTED LIVING FACILITY	6753 CARPEL DRIVE NEW PORT RICHEY, FL 34653

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

0000 Initial Comments

Assisted Living Facility

A complaint investigation (CCR# 2016001757) was conducted at Villa Rose Assisted Living Facility on . . / . . Villa Rose, Assisted living Facility, had deficiencies at the time of the investigation.

0028 Resident Care - Activities of Daily Living

Based on observation and interview the facility failed to offer supervision of assistance with daily living for 3 of (#2, #4, #7) 7 residents.

Findings included:

During observation of the residents on . / . . / . . at 12:00 noon resident #4 stayed in his . of the day and did not come out for his meal or medication. The staff working at the facility attempted to get the resident up and to take his medication but the resident refused. The resident stated he did not sleep all night planned to sleep most of the day. The resident refused to interview.

Resident 2 # was observed walking to the . her . a nightgown and she was barefoot. She was observed sitting in her . hours. The resident refused to speak when addressed.

Resident# 7 was observed siting at the table during lunch watching other residents eat. The resident rocked back and forth and did not eat her lunch. The staff stated she does not eat much. There wasn't anyone encouraging the resident to eat. The resident was not . The resident had a black heavy mustache.
The staff (A) stated the resident did not allow anyone to shave her face.
Staff (A) stated she does not assist residents with showers, she just stays at the facility so the administrator can leave.

Class III

0152 Physical Plant - Safe Living Environ/Other

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953473	05/11/2016
NAME OF PROVIDER OR SUPPLIER **VILLA ROSE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **6753 CARPEL DRIVE** **NEW PORT RICHEY, FL 34653**	

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

Based on observation and interview the facility failed to ensure they provide a safe living environment for 8 of (#1, #2, #3, #4, #5, #6, #7) 7 Resident that live at the facility.

Findings included:

The facility is an older structure and needs repair. During a tour of the facility at approximately 10:00a.m. the surveyor observed a front window that is being held shut with bricks on the outside window to hold it closed.
The front has outside seating area for the residents. The chairs are dirty , a dish full of cigarette butts has been left out on the ground. An old coffee table that has rotted and is used to set soda cans and a container of cigarette butts. The outside of the door is dirty.
Disposable plastic lawn bags filled with resident clothes are left in the front of the house to kill bed bugs
The kitchen cabinets are old and starting to disintegrate.
The windows and screens are so dirty you can't see clearly outside. The back yard has out side patio furniture that is being used to spread out bed linen to dry.
A travel trailer is parked in the back yard. Staff stated that is where the administrator lives and sleeps at night.
The living , large with sofa's and chairs that are being used to hold the facility linens.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Villa Rose Assisted Living Facility
6753 Carpel Drive
New Port Richey, FL 34653

RE: CCR# 2016001757

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on , 2016, by representative(s) 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.

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90