STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968466 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF DELRAY WEST	5859 HERITAGE PKWY DELRAY BEACH, FL 33484

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0007 Reg. # 429.26(11) FS; 58A-5.0181(1) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) *[initials]*	DATE 8/16/16	SIGNATURE OF SURVEYOR *[signature]*	DATE 8/16/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/28/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: EFGQ12

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968466	R 08/08/2016

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

0000 Initial Comments

A licensure complaint survey revisit to CCR# 2016002831 was conducted on 8-5-16 to 8-8-16. The facility had uncorrected deficiencies identified during the revisit; A 0025 and A 0165. The facility had one additional citation identified; A 0165.

0025 Resident Care - Supervision

Based on observation, interview and record review, the facility failed to provide adequate assisted living services to 4 out of 10 residents (Residents #5, 8, 9 and 10)by not properly supervising the level of personal care the residents required to promote their safety and well-being.

The findings include:

a) Review of resident #9's health assessment dated on - indicated that she was diagnosed with and had physical/sensory limitations due to ataxia. Review of this assessment indicated that the resident needed supervision with eating, and transferring activities of daily living (ADLs).

Review of the facility records indicated that resident #9 on the floor in her - at 9:45am due to loss of balance. Review of this record indicated that the resident transferred without supervision and the facility did not consider the resident's physical/sensory limitation of ataxia as a contributor of her on -. Review of this record indicated that the resident had right hip pain and was transported to the hospital for emergency medical treatment on -.

Review of the facility records indicated that resident #9 on the floor in her - at 9:10am due to loss of balance. Review of this record indicated that the resident attempted to transfer without supervision and the facility did not consider the resident's physical/sensory limitation of ataxia as a contributor of her on -.

Review of resident #9's physical ( ) screen dated on - indicated that the resident needed to be closely supervised with her ADLs. Review of the physician order dated on - - indicated that the resident needed supervision with ambulation and must use a walker as an assistive device for ambulation.

Review of the facility records indicated that resident #9 on the floor in the hallway on - at 1:22pm due to loss of balance and unsteady gait. Review of this record indicated that the resident was ambulating without supervision and was not using her walker as an assistive device during this

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Review of this record indicated that the resident's condition caused her to forget to use the walker as an assistive device during this . Review of this record indicated that the facility did not implement any new interventions to reduce the potential of a reoccurrence after her on .

Review of resident #9's screen dated on indicated that the resident needed assistance with transfers, including sit to stand activities, due to a change in the resident's mobility status.

In an observation on at 1:00pm in the dining , resident #9 attempted to transfer out of her chair for approximately 10 minutes. The resident presented to be distressed as she struggled to move her upper extremities and to have the necessary strength to elevate out of the chair at this time. In observations throughout this time, the resident's walker was placed next to the resident's chair and there were no facility staff members present to assist or supervise the resident with transferring her out of the chair.

In an interview with the memory care unit (MCU) supervising nurse on at 2:50pm, she stated that the facility did not implement any new interventions to reduce the potential of a reoccurrence after resident #9's on . She stated that she did not consider resident #9's screen dated on , in which the physical evaluated the resident with a change in mobility status, because she felt that the resident did not presently need assistance with transfers, including sit to stand activities. She stated that she based the resident's present daily personal care needs from the facility service sheet which she last updated on and it required the resident to be supervised with her transfers.

In an interview with the administrator on at 3:00pm, he stated that he expected the facility direct care staff, including the nurses, to follow the most current physician-ordered physical evaluation for any resident to ensure their safety and well-being.

In an observation on at 1:15pm in the dining , resident #9 attempted to transfer out of her chair for approximately 5 minutes. The resident presented to be distressed as she struggled to move her upper extremities and to have the necessary strength to elevate out of the chair at this time. In observations throughout this time, the resident's walker was placed in the hallway and there were no facility staff members present to assist or supervise the resident with transferring her out of the chair.

b) In an observation on at 1:30pm in the dining , resident #5 transferred from sitting to standing without supervision from a facility staff member. The resident presented to be unstable during this transfer due to continuous shaking of his lower and upper extremities.

In an interview with caregiver B on at 1:35pm, she stated that she did not observe or supervise resident #5 in the dining he transferred from sitting to standing a few minutes before and that

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there were no other staff members present to supervise the resident at that time. She stated that the resident needed supervision with transfers and ambulation.

c) Review of resident #10's health assessment dated on 7-13-16 indicated that he was diagnosed with and . Review of this assessment indicated that the resident needed assistance with all of his activities of daily living (ADLs), including eating. Further review of this assessment indicated that the resident did not receive any mechanically altered foods. Review of the resident's hospice notes dated on indicated that the resident needed "maximum care" with his ADLs and his needs must be anticipated.

In an observation on at 12:25pm in the dining , resident #10 was eating unassisted using his hands. The resident was picking up the tuna salad and lettuce with his fingers from the plate to his mouth at this time. In an interview with the staff nurse on at 12:30pm, she stated that it was okay for resident #10 to use his bare hands to eat because he ate independently and did not require assistance.

In an interview with the staff nurse on at 12:50pm, she stated that it was also okay for the facility direct care staff member (caregiver) to supervise resident #10 with eating or to allow him to eat without any supervision or assistance, because it was up to the individual caregiver to provide any level of care the resident needed.

d) Review of resident #8's health assessment dated on indicated that she was diagnosed with and had trouble walking due to physical/sensory limitations. Review of this assessment indicated that the resident needed physical and occupational (/OT) evaluations. Review of this assessment indicated that the resident needed supervision with bathing and dressing, and was independent with all of her ADLs. Review of the resident ' s record indicated that there was no OT clinical documentation to determine the resident ' s present functional status.

In an interview with the MCU supervising nurse on at 12:45pm, she stated that the facility did not have available any of resident #8's OT clinical documentation and she was not aware of the reason why the physician ordered this on . She stated that since she did not know if the resident received any OT treatments after or the outcome of the OT evaluation, she was not aware of the resident's functional status. She stated that the resident's functional needs may be different than what the facility was currently offering the resident.

Class III

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0030 Resident Care - Rights & Facility Procedures

Based on observation, record review and interview, the facility failed to provide a safe and decent living environment to the residents. This is evident by the facility staff allowing an unauthorized visitor access to the secured unit and allowing this visitor to roam within the unit jeopardizing the safety of the residents in the unit.

The findings are:
Review of the facility resident census list dated on - indicated that there were 30 residents living inside the memory care unit (MCU.). Further review of sampled residents resident records documented the residents suffered from .

In an observation on - at 1:25pm, there was an unidentified male walking in the MCU hallway by the resident medication cart next to the dining . In an observation at this time, some MCU residents finished their lunches and walked out of the dining the hallway, and into the activity . In observations at this time, staff members were present in the MCU dining , hallway and the activity . However, no staff members acknowledged the presence of this unidentified male while working; no person questions his presence in the unit.

In an observation on - at 1:45pm the unidentified male was sitting on the couch in the television the west end of the MCU. In an interview with the unidentified male at this time, he stated that he knew he was inside a resident common-area and that he was a facility volunteer. He stated that he had been in the MCU area for about 30 minutes and he was responsible to serve the residents' food during lunch time, but he was not required to serve the residents that day. He stated that he did not have to report to any facility staff member. Still no staff member acknowledged the presence of this unidentified male while working; no person questions his presence in the unit.

In an interview with the staff nurse on - at 1:50pm, she stated that she did not know any volunteer who was in the facility's MCU. She stated that the facility's MCU was a secured unit to maintain the safety and well-being of all the residents living in it.

In an interview with the MCU supervising nurse on - - at 1:55pm, she stated that she did not know any volunteer who was in the facility's MCU. She stated that if there was a visitor or a volunteer inside the MCU, she was supposed to have been informed of this.

In an interview with caregiver B on - at 2:10pm, she stated that she invited her minor son, who was , to come inside the MCU and she did not notify the MCU supervising nurse of this. She stated that she gave access to her son through the fence gate located on the east end of the MCU

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property, by unlocking it and allowing him to enter the MCU common areas, which placed him in direct access with the MCU residents. She stated that her son was a volunteer at the facility and she was aware that she needed to notify her if she was to have a visitor in the facility.

Review of the facility's employee standards and guidelines handbook dated documented the following. Staff members are not permitted to have visitors while on duty. The Executive Director must approve exceptions each and every time.

In an interview with the Administrator on - at 2:15pm, he stated that Caregiver B violated facility employee rules and placed the MCU residents at risk by allowing a visitor inside the MCU without approval from him.

Class III

0165 Risk Mgmt & QA: Adverse Incident Report

Based on interview and record review, the facility failed to determine that it could exercise control to prevent an adverse incident involving 1 out 2 residents (Resident #11) by not providing a complete investigation of an adverse incident.

The findings include:

Review of the facility's 15-day report dated on - indicated that resident #11 while walking and her pelvis which required her to be hospitalized on - . Review of this report indicated that the resident lost her balance and was not receiving assistance while she was walking. Review of this report indicated that the facility determined that the incident was not an adverse incident after conducting a 'complete investigation.' Further review of this report indicated that the facility did not provide proof that the facility staff assessed the resident during ambulation before she on - and the facility did not provide the name of any staff member who was involved or witnessed this incident.

Review of resident #11's health assessment dated on - - indicated that she was diagnosed with , decreased memory, and needed a cane for ambulation due to physical/sensory limitations. Review of this assessment indicated that the resident needed supervision with bathing and was independent with all of her other activities of daily living (ADLs.) Review of the resident's service sheet dated on - indicated that the resident needed supervision with ambulation and transfers.

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Review of resident #11's physical ( ) evaluation dated on 4-18-16 indicated that the resident had a high risk for due to an alteration in ambulation and required assistance with ambulation due to decreased endurance and mentation. Review of the resident's treatment notes dated on - indicated that the resident required assistance with ambulation for safety reasons. Review of the resident's treatment notes dated on indicated that the resident required assistance with ambulation to maintain midline position and the resident was a high risk for .

Review of the facility records indicated that resident #11 developed a on her left thigh on - at 7:15am due to an unknown cause. Review of this record indicated that the facility did not implement any new interventions besides "monitor res." to reduce the potential of a reoccurrence after the resident's unknown injury on - .

Review of the facility records indicated that resident #11 was "eased" to the floor in the dining - at 9:45am due to loss of balance and body "giving out." Review of this record indicated that the cause of this incident was due to the resident's unsteady gait and the facility did not implement any new interventions besides "monitor" to reduce the potential of a reoccurrence after the resident's on - .

Review of the facility records indicated that resident #11 was found on the floor in the memory care unit's sitting area on - at 7:00am due to a suspected . Review of this record indicated that the resident complained of head pain while she was lying on the floor and she was sent to the hospital after this . Review of this record indicated that the cause of this was due to the resident's unsteady gait and the facility did not implement any new interventions besides "monitor" to reduce the potential of a reoccurrence after the resident's on - .

Review of the facility records indicated that resident #11 in the MCU hallway on - at 7:45am due to loss of balance. Review of this record indicated that the resident was sent to the hospital after this and no physical injuries were described in the facility incident report or investigation forms dated on - and - . Review of this record indicated that the cause of this was due to the resident's unsteady gait and the facility did not implement any new interventions besides "monitor" to reduce the potential of a reoccurrence after the resident's on - .

Review of the facility's 15-day report dated on - indicated that resident #11 suffered a pelvic due to a in the MCU hallway on - at 7:45am. Review of this report indicated that the facility sent the resident to the hospital by emergency transportation and that the facility staff could not have prevented this resident's accident.

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In an interview with the corporate nurse on 8-8-16 at 10:40am, she stated that the facility did not implement any new interventions to reduce the potential of a reoccurrence after resident #11's on - and - . She stated that the resident required supervision with ambulation and transfers, and was not aware of the resident's evaluation results or if the resident had any changes in her function since - . She stated that the resident suffered a to her pelvis when she on - and it may have been a re- of her pelvis from an initial caused in 2016. She stated that the hospital refused to treat her injury on - and immediately sent the resident back to the facility. She stated that since the facility could not deliver the personal care needed for the resident on - , which at the time included assistance with ambulation, she arranged for hospice to provide a 24-hour private aide on - . She stated that the resident was subsequently discharged from the facility on or about - to another assisted living facility which could meet all of the resident's personal care needs.

In an interview with the medication technician on - at 11:15am, he stated that he was present when resident #11 in the MCU hallway on - at 7:45am and he was not directly supervising the resident because he was tending to his medication duties by the medication cart and he was not within proximity of the resident during this event. He stated that he saw the resident walking independently on - at approximately 7:45am and when she came out of the dining the hallway, she lost her balance and . He stated that he did not know that resident #11 had recently her pelvis due to a , that she was a high risk or that she needed assistance with ambulation. He stated that during the facility's investigation of this resident's incident on - , he was not asked by any staff member any questions about the specific care he thought resident #11 needed.

In an interview with resident #11's daughter on - at 12:00pm, she stated that she felt that the facility did not take adequate care of her mother because it did not have enough competent direct care staff members to deliver the required personal care services. She stated that the facility was not prepared to provide assisted living care for her mother and it initially refused to re-admit her mother after they sent her to the hospital on - . She stated that she had to beg the corporate nurse to "re-admit" her mother after her mother's and when her mother was returned from the hospital on - because she had not planned to discharge her mother to another facility at the time. She stated that once her mother was "re-admitted" to the facility on - , the facility had to place her mother under hospice care primarily for her mother to receive assistance with her ADLs, which was a basic assisted living service the facility should have been able to provide. She stated that her mother was currently in a new facility and did not presently require any hospice care.

In an interview with the administrator on - at 2:25pm, he stated that he submitted the facility's 15-day report to the Agency on - and that this report did not include proof that the facility staff assisted resident #11 during ambulation before she on - or any reason why the facility was not

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able to provide this assistance. He stated that this report did not include the name of any staff member who was involved or witnessed this incident, or any detail of the level of ADL care resident #11 needed. He stated that he was not aware of the resident's special precautions or risks, nor the resident's required level of ADL care in 2016. He stated that he relied on the facility staff to conduct a complete investigation so he could determine if the facility could have exercised control over resident #11's accident. He stated that the incident narrative in the facility's 15-report dated on did not have enough detail to determine whether resident #11 could have received assistance by the facility staff during ambulation to prevent her on . He stated that since he was absent during the first half of 2016, he did not perform the facility's analysis to review every residents' change of functional status so the facility can adjust the personal care services it provides to the facility residents.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Grand Villa Of Delray West
5859 Heritage Pkwy
Delray Beach, FL 33484

Dear Administrator:

This letter reports the findings of a **second** State Licensure Revisit Survey conducted on 8, 2016 by a representative of this office.

Attached is the provider's copy of the State Form, 5000-3547 and Revisit Report, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than , 2016.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosures: State forms 5000-3547 and Revisit Report

YOSF

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