



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 1, 2016

Administrator
Victoria's Dedicated Retirement Home II Inc
2535 Nw North River Drive
Miami, FL 33125

Dear Administrator:

This letter reports the findings of a Standard Biennial licensure survey that was conducted on January 1, 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 January 1, 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 surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

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**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 09/20/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967753	(X3) DATE SURVEY COMPLETED 08/16/2016
NAME OF PROVIDER OR SUPPLIER VICTORIA'S DEDICATED RETIREMENT HOME II INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2535 NW NORTH RIVER DRIVE MIAMI, FL 33125	

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

0000 Initial Comments

A Standard Biennial Survey was conducted on [redacted], Victoria's Dedicated Retirement Home II Inc. had no the following deficiencies found at time of the survey:

0010 Admissions - Continued Residency

Based on observations, record review, and interview, the facility failed to have an updated health assessment that documented significant changes in activities of daily (ADLs) levels for 1 out of 15 (#4) sampled residents.

Findings included:

Observation on [redacted] at 8:05 AM showed Resident #4 asleep in bed in [redacted] # [redacted] with two hospice staff member near her bed.

The hospice nurse stated on [redacted] at 8:05 AM "Resident #4 was on continue care."

Record review on [redacted] showed that Resident #4 (admitted on [redacted])'s health assessment (AHCA form 1823) dated [redacted] documented the resident needed assistance with all activities of daily living (ADLs). Further review showed the resident needed assistance with self-administration of medication and that the resident was not bedridden.

During an interview on [redacted] at 12:00 PM, the facility's Administrator acknowledged that health assessment did not document changes in condition for Resident #4.

Class III

0026 Resident Care - Social & Leisure Activities

Based on observation, record review, and interview, the facility failed to provide social, recreational or educational activities to a census of 15 residents.

Findings included:

Observations during survey on [redacted] from 8:00 AM to 3:00 PM found residents were watching television in the living [redacted] and dining [redacted], others resident in their [redacted]. Facility staff did not offer any activities to the residents.

Record review found the activities calendar stated "Dominos 2-4 PM."

During an interview on [redacted], Resident #6 stated the facility's owner mom brought a Domino games and we play only one time. He stated the only thing that we did here is to watch television.

During an interview on [redacted] at 12:41 PM, Staff E (caregiver) stated sometimes we take them to the patio for a walk at 9:00 AM.

During an interview on [redacted] at 10:53 AM, Staff F (caregiver) stated activities, only birthday but I did not have participated in any one yet.

Class III

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0030 Resident Care - Rights & Facility Procedures

Based on observation, record review, and interview, the facility failed to have a signed consent form for bed rails ordered by hospice for 1 out of 15 sampled residents (Resident #4).

Findings include:

Observation on [redacted] at 8:15 AM during facility tour showed Resident #4 had full bed rails attached to her bed.

Record review showed Resident's #4's daughter signed a half bed rail consent. Record review found a bed rail order from hospice but the consent form did not match the order.

During an interview on [redacted] at 12:40 PM, the facility's Administrator stated that he didn't have informed consent for the use of full bed rail.

Class III

0052 Medication - Assistance with Self-Admin

Based on observation and interview, the facility's staff failed to follow procedure during assistance with self-administration of medication for 1 out of 15 (#10) sampled residents.

Findings included:

Observation on [redacted] at 12:12 PM Staff E (caregiver) assisted Resident #10 with self-administration of medication. Staff E (caregiver) did not wear glove; Staff punched the medication bingo card so the medication could go into hands, and then placed the medication pill into Resident #10's hands. Staff E (caregiver) say or read the medication label for the following: [redacted] 0.5 MG, [redacted] 1 MG, and [redacted] 100 mg.

During an interview on [redacted] at 3:15 PM, the facility's Administrator acknowledged that Staff E did not did not follow that correct procedure at the time of med pass.

Class III

0054 Medication - Records

Based on record review and interview, the facility failed to maintain a daily medication observation record (MOR) for each resident who receives assistance with self-administration of medications for 15 out 15 (1-15) sampled residents.

Founding included:

Record review on [redacted] at 10:05 AM showed MORs were not initialed by facility staff on [redacted] for the night dosage (8:00 PM) and [redacted] for the morning dosage (8:00 AM) for the residents (15) at the facility.

During an interview on [redacted] at 10:16 AM, the facility Administrator acknowledged during the reviewed that the MORs were completed.

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Class III

0056 Medication - Labeling and Orders

Based on observation, record review, and interview, the facility failed to assist resident with self-administration of medications per doctor's order for 1 out of 15 (#10) sampled residents.

Findings included:

Observation on [redacted] at 12:12 PM found Staff E assisted Resident #10 with self-administration of [redacted] 0.5 MG and [redacted] 100 mg,

Record review showed the medication observation records stated the [redacted] 0.5 MG was ordered for 2:00 PM and [redacted] 100 mg was ordered for 5:00 PM.

During an interview on [redacted] at 12:23 PM, the facility's Administrator stated the doctor told me that give her medication at 12:00 PM.

The facility was unable to show any changes in the medication orders for Resident #10.

Class III

0077 Staffing Standards - Administrators

Based on record review and interview, the facility failed to appoint in writing a separate manager for each facility, the facility's Administrator supervised more than one facility.

Findings included:

Record review on [redacted] showed that the facility did not have a manager's record or documentation in writing verifying they have appointed a manager.

The Florida health finder website showed the Administrator supervised two assisted living facilities.

During an interview [redacted] at 10:00 AM, the facility's Administrator stated that facility manager was the owner. He acknowledged that employment application showed that she is the owner and no new application on record or documentation that she was the manager of the facility.

Review of Staff B's employment application showed hire dated on [redacted], position "owner." There was no proof that the owner was CORE trained.

Class III

0081 Training - Staff In-Service

Based on observation, record review, and interview, the facility did not ensure that 1 out of 6 (Staff E) sampled employees received in-service training within 30 days of employment.

Findings included:

Observation on [redacted] at 8:00 AM found Staff E in the facility assisting residents with activities of daily living, census of 15.

Personnel record review conducted [redacted] showed, that Staff E (caregiver) hired on [redacted] did not

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have documentation that she received in-service training within 30 days of employment that covers the following:

Activities of Daily Living (ADL) and Behavioral Needs Training.

Elopement response training

Emergency preparedness & Evacuation training

Incident reporting training

Recognizing/ Reporting Neglect & training

Nutritional & Safe Food Handling

During an interview at 9:49 AM, the facility's Administrator reviewed Staff E personnel record. He stated that "I knew that one staff missing a lot of training." He stated that she have the training next week.

Class III

0125 Fiscal - Surety Bonds

Based on record review and interview, the facility failed to have a surety bond with the minimum bond proceeds that equal twice the value of the residents' monthly aggregate income for 4 out of 15 (#s 1, 5, 9, and 11) sampled residents.

Findings included:

During an interview on at 12:48 PM, Resident #5 stated my check go directly to the facility.

During an interview on at 1:30 PM, Resident #9 stated my check did go to the facility, the amount of \$790.00.

Record review on showed that Resident #1's check was mailed on, the facility was the payee.

During an interview on at 3:15 PM, the facility's Administrator acknowledged that facility was the payee for four Residents (#1, #5, #9, and #11). He stated the facility did not have surety bound.

Class III

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to provide a safe and clean living environment.

Findings Included:

During the facility tour on at 8:00 AM found the facility living conditioner vent have black substances around it. Further observations showed the dining 's ceiling had repairs completed but needed to be painted.

During an interview on at 3:15 PM, the facility Administrator stated "I don't know what happened there because the facility owner cared a lot about the facility. She liked to have the facility clean."

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Class III

0162 Records - Resident

Based on record review and interview, the facility failed to have documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney for 1 out of 15 (Resident #4) sampled residents.

Findings included:

Record review on showed the contract between Resident #4 and the facility was signed by a family member (daughter). Record review showed the facility failed to have a health care surrogate appointed, health care proxy, guardian or a power of attorney (POA) for Resident #4.

During an interview on / / at A 12:00 PM, the facility's Administrator stated that he did not have POA on record. He stated Resident #4's daughter comes here one time a year to see her because she lives on Tampa.

Class III

L243 LMH - Training

Based on record review and interview, the facility failed to ensure that 2 out of 6 (A and B) sampled employees received 3 hours of continuing education in Limited Mental Health (LMH).

Finding included:

Record review found Staff A's last LMH training was dated and Staff B's last training was dated / . The facility failed to ensure that staff received 3 hours of continuing education in LMH.

On / / at 9:50 AM, the facility's Administrator acknowledged that continue education for limited mental health training for Staff A and B was expired.

Class III

Z828 Administrative Fines: Violations

Based on observation, record review, and interview, the facility failed to obtain a licensure capacity increase prior to providing personal care and meals to six residents. The facility provided services to residents outside current license capacity of 14.

Findings included:

During the facility tour on at 8:05 AM with Staff E (caregiver) observe Resident #3 in # sitting on her bed. Resident #3 stated "please close the door I want to sleep." Resident #2's .

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yelled "I do not want the door close. I do not trust her; she does not sleep at night. She's been up all night and now she want to sleep. She does not slept at night and she does not allowed me to sleep either."

Facility finder review on showed that the facility was licensed for 14 beds.

Record review showed Resident #3 was admitted on . The facility had agreement for daycare dated showed that drop off hour 7:00 Am and Pick up 7:30 PM.

During an interview on at 8:30 AM, Resident #3 stated "I'm living here for a few days. I have issues with my because I want to sleep and she do not want me to close the door." She stated "I go to physical and I this is a lot of work and I need to rest."

During an interview with the facility administrator on / at 3:15 PM he acknowledged that facility is license for 14 residents and he had 15 at this time. He stated she was admitted but she is living at the end of this month that why I did the daycare file.

Unclassified