STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968466	12/01/2016
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#2016013107, was conducted on 15, 2016 and 1, 2016 at Grand Villa Of Delray West (License #12362). The allegations were not substantiated, with a related deficiency identified.

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure the health assessment (AHCA Form 1823) was completed with accurate information to reflect the resident's status, for 1 out of 3 sampled residents (Resident #1).

The findings included:

On / at 10:30 AM, Resident #1 was interviewed and stated he was provided his medications from facility staff. He was able to administer his own medications with staff supervision and the facility secured his medication in central storage. The resident's representative was interviewed at 10:40 AM on this date and stated the same.

Review of the resident's health assessment dated revealed on page 2 that the resident required "administration" of his medication rather than "assistance with self-administration". The "yes" or "no" inquiry as to whether or not the resident's needs could be met in an ALF was marked "no". A notation below indicated that the resident required "nursing" (circled) and stated, "needs nursing to administer daily medication."

During interview with the Administrator and the Regional Nurse at 10:45 AM on /, these findings were acknowledged. They confirmed that the resident did not require nursing to administer his medications and that the facility provided unlicensed staff to assist residents with self-administration for this resident. The health assessment was marked incorrectly on page 2.

Class III

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interviews and record review, the facility failed to ensure the cause of an injury of unknown origin was reviewed, for 1 out of 3 sampled residents (Resident #2).

The findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968466	12/01/2016

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

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

On 11/15/16 at 10:45 AM, the Administrator stated during interview that the facility's process for prevention included incident reporting with the date of the incident and circumstances documented on a facility form. The information would then be entered into the facility's "ECP system" for electronic tracking of as a tool for prevention.

On / at 12:30 PM, Resident #2 was observed in the Memory Care building with a black and blue mark under her left eye. The resident was unable to answer questions about the injury due to . During interview with the Memory Care Director (MCD) at 12:45 PM, she stated the resident's injury had been documented on the Alert Chart Log as part of the facility's prevention procedures. The Alert Chart Log was reviewed with the MCD at this time and showed a "left eye cause unkown" documented on / . The MCD stated there "should be an incident report completed by the nurse" as part of the facility's prevention procedures. Review of the resident's observation notes showed documentation of " on face" from through . There was no documentation in the resident's observation notes of facial until / . Documentation showed on / , " noted to left eye. Cause unkown. Resident were asked what happened but can't remember."

On / at 2:00 PM, the MCD and Regional Nurse (Registered Nurse/RN) stated that the resident's current left eye was due to a previous on when the resident had an injury to her forehead. The incident report for the on was reviewed with the RN at this time and showed no documentation of injury to the resident's left eye. The MCD stated an incident report was not completed for the resident's current left eye as it was attributed to the resident's on .

On / at 2:15 PM, the Licensed Practical Nurse (LPN), who noted the resident's eye on / , stated the left eye is a new injury and not related to the resident's previous on . At this time, the Administrator, RN and MCD acknowledged that the new injury of unknown origin identified by the LPN on / had not been investigated with a completed incident report to document the circumstances related to the incident. Additionally, the resident's representative had not been notified of the incident. An Incident Report was subsequently completed with documentation showing the staff involved in the discovery of the injury and that resident's representative was notified of the incident on / .

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

RE: CCR #2016013107

Dear Administrator:

This letter reports the findings of a state lcomplaint survey that was conducted on , 2016 by a representative 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

Delray Beach Field Office
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