STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911225	**02/15/2017**
NAME OF PROVIDER OR SUPPLIER **GRAND VILLA OF ENGLEWOOD**	STREET ADDRESS, CITY, STATE, ZIP CODE **925 SOUTH RIVER ROAD** **ENGLEWOOD, FL 34223**	

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

0000 - Initial Comments

An unannounced complaint survey for CCR #2016013534 and CCR #2016014103 was conducted on at Grand Villa of Englewood, an assisted living facility (license #5501), in Englewood, Florida.

Complaint #2016013534 contained 1 allegation, which was substantiated with citation A0030.
Complaint #2016014103 contained 2 allegations, of which 1 was substantiated with citation A0010.

The following is a description of the deficiencies.

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on records reviewed, observations and staff interviews, the facility failed to ensure 2 (Residents #3 and #6) of 6 residents' records met the criteria for continued residency in order to continue to live at this facility.

The findings included:

1. Observation on at 9:55 a.m., showed Resident #3 sitting in the living Building E. At 9:55 a.m., Staff B said Resident #3 requires a lot of care from the staff. At 10:00 a.m., an assessment of Activities of Daily Living (ADLs) was conducted. Staff B asked Resident #3 to wheel herself to her Resident #3 did not conducted this ADL. Staff B said Resident #3 does not wheel her wheelchair. Staff have to do this for her. Resident #3 was brought to her . Staff B wheeled her to her . Staff B and C conducted assessments for toileting, dressing, and . Observations throughout this assessment showed Resident #3 did not participate in these ADLs. Interviews with Staff B and C on at 10:10 a.m., were conducted. They both said Resident #3 requires total care with her ADLs. She can eat and stand with assistance. During the assessment for dressing and at on 10:20 a.m., Resident #3 started yelling out. Interview with Staff B on at 10:20 a.m., revealed Resident #3 does this many times. When this happens Staff B will do the ADLs as total care. A review of Resident #3's health assessment dated showed she requires assistance with all of her ADLs except with eating she is independent. Resident #3 requires total care with ambulation, dressing, , bathing, toileting.

2. Observation on at 12:45 p.m., showed Resident #6 finishing her lunch in the dining . An assessment was conducted with Resident #6 on at 12:55 p.m., for her ability to participate in her ADLs. Staff B asked Resident #6 to wheel herself to her . Resident #6 did not conduct this ADL. Staff B said Resident #6 does not wheel herself and staff have to do this for her. Staff B brought

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Resident #6 to her . Staff B and another staff lifted Resident #6 out of her wheelchair and set her on her bed. Resident #6 did not participate in this transfer. She did not bear her weight on the ground. Staff B and the other staff changed her adult brief by pulling her pants and adult brief down to her knees while Resident #6 was standing, the placed her on her bed, cleaned her, put a clean brief on and pulled her pants up by turning her while lying on the bed. Resident #6 did not participate in this ADL. Resident #6 was not able to dress herself with assistance. Staff B was interviewed on at 12:55 p.m. during this assessment. She stated Resident #6 requires total assistance with and bathing. She does not participate in both of these ADLs. She keeps her arms tucked close to her chest. A review of Resident #6's health assessment dated showed she requires assistance with bathing, , dressing and toileting. Resident #6 requires total care with ambulation, dressing, , bathing, transfer and toileting.

3. Through interviews with Staff B and C and observations of Residents #3 and #6 during these ADL assessments shows they both require total assistance with several ADL and do not meet the criteria for continued residency for assisted living facilities. Further review of their records shows there are no 45 day discharge notices.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on one of two resident records reviewed, facility and hospital staff interviews and a review of the ambulance run report, the facility failed to honor Resident #15's rights by not providing him a 45 day discharge notice prior to him being discharged from the facility. Resident #15 was sent to the hospital and was not allowed to return to the facility.

The findings included:

1. An interview was conducted with the Staff K on at 12:15 p.m. She said Resident #15 was sent to the hospital from Grand Villa of Englewood, an assisted living facility (ALF) on due to and agitation. He was medically cleared to go back to the ALF on 11/ . When Resident #15 returned to the ALF the staff at the facility would not allow him back. He was then discharged from the hospital three days later to another ALF. He did not require a higher level of care. On Resident #15's hospital record was reviewed. It showed he was sent to the hospital on for " ." He was discharged from the hospital on showing "The patient's condition is stable and appropriate for discharge from the emergency department." A review of Resident #15's closed record has an incident report dated showing he was sent to the hospital on for threatening staff and exit seeking behavior.

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An interview was conducted with Staff G on ... at 1:00 p.m. She said Resident #15 was threatening towards staff and they could not keep in in the memory unit. He was able to find his way to the stairwell. He was taken to the hospital emergency department. She called the hospital and told them the ALF could not keep him safe at this facility. When the paramedics returned Resident #15 to the ALF she told them the ALF will not take Resident #15 back.

An interview was conducted with the administrator on ... at 2:00 p.m. He confirmed he did not allow Resident #15 back in the facility from the hospital. He did not give Resident #15 or his responsible party a 45 day discharge notice.

A review of the run report from the ambulance showed during their transport Resident #15 had no changes. "Staff...claimed that they were not going to accept the , (patient) back." The drivers sat in the ALF's parking lot for over 2 hours until the hospital staff directed them to come back to the hospital with Resident #15, which they did. Resident #15 did not return to the ALF and was discharged on 11/ .
A review of the facility contract showed on page 32, K, the facility is to give the resident "At least 45 days notice of relocation or termination of residency from the facility..." There was no documentation from a physician showing Resident #15 required a higher level of care due to medical issues or conduct that is harmful to others. The facility failed to honor Resident #15's right to return to the facility when his condition was stable once leaving the hospital and not providing him a 45 day discharge notice prior to discharging him from the facility.

Class III