STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968496	**05/25/2017**
NAME OF PROVIDER OR SUPPLIER **VILLASOL GROUP INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **14300 SW 36 STREET** **MIAMI, FL 33175**	

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

0000 - Initial Comments

A standard biennial survey was conducted on , 2017. Villasol Group Inc with limited mental health component, license #12401, had the following deficiencies identified at the time of the survey:

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

Based on record review and interview, the Assisted Living Facility failed to have accurate health assessments that documented the completed medical history and diagnoses of three (Residents #1, #3, and #4) out of six sampled residents.

Findings included:

Review of Resident #1's record revealed the health assessment (AHCA form 1823) completed on did not include the medical diagnosis under which Resident #1 was admitted to hospice. Medical history and diagnoses included , , , , and . It showed that resident was not ambulatory. On page 2 of health assessment activities of daily living showed that ambulation was not applicable for Resident #1 but at the bottom showed that Resident #1 was not bedridden. Review of Resident #1's hospice record showed that admission date was on and admitted diagnosis was Degenerative of nervous system.

Review of Resident #3's record revealed the health assessment (AHCA form 1823) completed on did not include the medical diagnoses under which Resident #3 was admitted to hospice. Medical history and diagnosis included , , , and . It showed that resident has gait. On page 2 of health assessment activities of daily living showed that ambulation was not applicable for Resident #3 but at the bottom showed that Resident #3 was not bedridden. Review of Resident #3's hospice record showed that admission date was on and admitted diagnosis was Degenerative of nervous system.

An interview on at 12:20 PM the Administrator stated, "It makes sense" after the Administrator reviewed the health assessments and found they did not include the hospice admitted diagnoses.

Review of Resident #4's record revealed the health assessment (AHCA form 1823) completed on did not include the residents complete medical history and diagnoses. Medical history and diagnoses on showed , , , , , , . Previous health assessment completed on showed under medical history and diagnoses: , , , , , surgery.

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An interview on at 1:40 PM the Administrator revealed Resident #4 had problems.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on record review and interview, the Assisted Living Facility failed to have licensed staff members administering medications to one (Resident #3) out of six sampled residents.

Findings included:

Review of Resident #3's MORs showed initial of a letter. It was not initialed as given on in the AM or in in the PM.

An interview on at 8:11 AM the Administrator stated, " Resident #3 took all her medicines this morning, his sister gave it to today and yesterday too."

Phone interview on at 8:14 AM Resident #3's sister revealed that she has not been in the facility earlier today (date of the survey) and she will be there later because she had a doctor appointment.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review, interview, and observation, the Assisted Living Facility failed to update the Medication Observation Records (MORs) each time medications are offered or administered.

Findings included:

Review of MORs of six out six sampled residents revealed that none of the medications had an scheduled time; they stated, "AM or PM".

Review of Resident #1's MORs showed initial of a letter. It was not initialed as given on in the AM or in in the PM. Review of Resident #3's MORs showed initial of a letter. It was not initialed as given on in the AM or in in the PM. Review of Resident #5's MORs showed that medicines were not initialed as given on in the AM or in in the PM.

An interview on at 8:07 AM the Administrator stated, "They do not have specific time, and

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generally we give them when they ate breakfast, between 2 or 3 PM and at bedtime."

An interview on at 8:11 AM the Administrator stated, "Resident #5 took all his medicines this morning. Resident #3 took all her medicines this morning, his sister gave it to today and yesterday too. Resident #1's nephew gave her medicines; yes, he gave them today and yesterday too."

Reconciliation of Residents #1, #3, and #5 revealed that medications for in the evening and for in the morning were missing from medication cards.

An Interview on at 2:54 PM the Administrator stated, "We give medicines to Resident #5 before leaving to program, as soon as he arrived, at 5 PM and at 9 PM."

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and interview, the Assisted Living Facility failed to keep medications locked at all times.

Findings included:

Observation on at 7:50 AM revealed that there were three medication boxes in the facility's refrigerator. Two out of three boxes were unlocked. Box one had a package of Xeroform Petrolatum Dressing, a package for Resident #3 with 10 mg , and a package for Resident #1 with 10 mg . Box two had a labeled for Resident #1 and an order of "to be opened by a hospice nurse only in case of emergency." Box two had a bottle for Resident #1 of Sulf 100 mg/5 ml and a bottle of 2 mg/ml, 650 mg, 10 mg, ( ) system 1.5 mg, and orally disintegrating 4 mg inside.

An interview on at 7:50 AM the Administrator stated, "They were supposed to be locked."

Class III

0125 - Fiscal - Surety Bonds - 429.27(2) FS; 58A-5.021(3) FAC

Based on record review and interview, the Assisted Living Facility provider failed to have a surety bond for residents that the facility serves as representative payee.

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Findings include:

An interview on at 10:43 AM the Administrator revealed that he was the payee for Resident #2.

Review of facility's record revealed that there was no poof that facility had a surety bond at the time of the survey.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record review and interview, the Assisted Living Facility failed to ensure that one out of four sampled staff members (Staff Member C) completed a minimum of 3 hours of continuing education related to Limited Mental Health (LMH) training.

Findings included:

Review of Staff C's personnel file revealed the hire date was on and the last 3 hours LMH training was on .

An interview on at 12:02 PM the Administrator revealed that he was not able to find it.

Class III