STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911225	08/03/2017
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 relicensure survey was conducted through at Grand Villa of Englewood, an assisted living facility (license #5501) in Englewood, Florida.

The following is description of the deficiencies.

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

Based on observation and staff interviews, the facility failed to follow established and recognized standards for administration of an inhaler to 1 (Resident #15) of 2 residents observed for assistance with self-administration of medications. Failure to follow manufacturer's instructions has the potential for Resident #15 to develop a fungal in the mouth and throat.

The findings included:

On at 8:19 a.m., during observation of assistance with self-administration of medications for Resident #15, Medication Technician (Med Tech) staff B gave Resident #15 (a medication used to help improve breathing) to inhale 2 puffs as ordered. After inhaling the 2 puffs, Resident #15 drank water from a cup and swallowed. Manufacturer's instructions for administration of include; "Rinse your mouth with water and spit the water out after each dose (2 puffs). Do not swallow the water. This will help lessen the chance of getting a ( ) in the mouth and throat." This instruction was not provided to Resident #15 before or after he self-administered the .

On at 8:25 a.m., Med Tech staff B said she was not aware of the need for Resident #15 to rinse his mouth with water, then spit the water out and not to swallow the water after use of .

On at 2:14 p.m., Resident #15 said he has never been instructed to rinse and spit with water and not to swallow the water after taking . He added "Is that why I have a tickle in my throat?"

On at 2:46 p.m., the facility Resident Care Supervisor confirmed that staff should be providing direction to residents' receiving to follow the manufacturer's instructions after inhalation of .

Class III

0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911225	**08/03/2017**
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)

Based on observation and staff interview, the facility failed to provide assistance with self-administration with medications by not reading the medication label prior to dispensing medications to 2 (Resident #15 and #16) of 2 residents sampled. This has the potential to lead to medication errors.

The findings included:

1. On at 8:19 a.m., Medication Technician (Med Tech) staff B assisted Resident #15 with self-administration of medications. Med Tech Staff B failed to read the label of any of the medications to Resident #15 prior to dispensing the medications or before he self-administered the medications.

On at 8:26 a.m., when asked why she did not read the medication labels to Resident #15, Med Tech staff B said, "If you have been giving the resident the same meds for a year do you still have to read the labels?"

2. On at 8:55 a.m., Med Tech staff D assisted Resident #16 with self-administration of medications. Med Tech Staff D failed to read the label of any of the medications to Resident #16 prior to dispensing or before she self-administered the medications.

On at 9:01 a.m., when asked why she did not read the medication labels to Resident #16, Med Tech staff D said, Resident #16 "Knows her meds and can read them better than me."

On at 2:46 p.m., the facility Resident Care Supervisor said all staff are aware of the policy to read the label to the resident when assisting with self-administration of medications.

3. On at 3:06 p.m., review of facility policy M-3, created revealed, "All Medication Technicians are required to complete this step. Take all scheduled medications in its original package to the resident. Read the following aloud to the resident for each medication prior to dispensing. I. Name II. Dosage III. Directions."

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review, staff interviews, and observation, the facility failed to complete a one day adverse incident report for 1 (Resident #14) of 11 residents observed during the initial tour.

The findings included:

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911225	08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF ENGLEWOOD	**925 SOUTH RIVER ROAD ENGLEWOOD, FL 34223**

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

Resident #1's observation record dated at 3:30 p.m., states "late entry 1 pm Resident lying in bed in changed (pullups). Aid went to residents get wipes for resident to clean her and came out of lying on left side on floor. Resident obtained a small on her left forehead. No noted. Sent to ECH for evaluation and treatment." On at 4:00 p.m., the observation record states "Probable cause of incident was resident aide did not have resident secure at time of and leaving area. Remind resident that rolling out of bed will cause injury to self. Resident alert to surroundings."

On at 10:30 a.m., Resident #14 was lying in bed and observed with black-green-purple brushing around eyes and left forehead hematoma.

In an interview on at 10:30 a.m., Licensed Practical Nurse (LPN) Supervisor, Staff E said Resident #14 on Saturday.

In a re-interview on at 1:00 p.m., interview with LPN, Staff E said the incident was reported to the family and Hospice, and called.

In an interview at 1:15 p.m., Resident Assistant ( ) Staff F said she was caring for Resident #14 when she off the bed. Staff F said she went to go get wipes and when she came back the resident was on the floor.

In a re-interview on 1:45 p.m., with Darcell McClelland, said she was not aware Resident #14 had an incident until today. She said normally an incident report is completed and she reviews it. She said a incident report was filed by staff but she had not reviewed it until today.

In a re-interview on 2:50 p.m., the facility Executive Director said there should have an Adverse Incident Report with AHCA. She said she would file that now and in service staff.

Class III