STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965579	02/23/2018
NAME OF PROVIDER OR SUPPLIER **VILLA ESMERALDA ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **10310 NW 30 COURT** **MIAMI, FL 33147**	

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

0000 - Initial Comments

A Complaint (CCR# 2017015233) Survey was conducted on , 2018 and concluded on , 2018. Villa Esmeralda ALF (license #9978) had deficiencies identified at time of the survey.

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

Based on record review and interview the facility failed to have a medical examination completed within 30 days of admission for one of seven sampled residents (Resident #5).

Findings included:

Record review revealed the admission /discharge log had Resident #5, who was admitted on .

Record review revealed Resident #5 did not have a health assessment in her file.

Interview on at 9:00 am Staff A stated, "The doctor will be here soon to see her."

Class III

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

Based on interview and record review the facility failed to have documentation for one of seven sampled residents (#7) who refused to take medications for almost a month. The facility also failed did not have any documentation that the doctor was informed that Resident #7 was not taking medications.

Findings included:

According to Staff A and B on at 7:31 am, "Resident #7 used to take all her medications daily; however, Resident #7 is refusing to take the medication, and we cannot force her to take her medications."

Record review revealed Resident #7's medication observation records (MORs) did not have written information or explanation why Resident #7 is not taking medications for almost a month. The facility failed to have written documentation regarding Resident #7 who was not taking medications. The facility also failed to contact the doctor to report a change in Resident #7's condition. Resident #7's health assessment dated had a diagnoses of , and .

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Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation and interview, the facility failed to encourage the residents to participate in social, recreational, educational and other activities within the facility and the community.

Findings included:

On at 10:00 AM Resident #3 and #5 were observed sitting in the living TV. Resident #1, 2, 4, and 7 were in their .

During an interview on at 8:14 AM, Resident #5 stated "I only watch TV here."

On at 8:27 AM Resident #3 stated "there are no activities here, we watch TV that's it."

Class III

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

Based on observation, record review, and interview, the facility failed to treat one of seven sampled residents with dignity and respect (Resident #2. The resident was found in bed drenched in , and the facility used a wheelchair and rolling walker as a physical to keep the resident in bed.

Findings included:

On at 5:30 am Agency staff arrived to the facility. The facility's fence was locked, the facility did not have a door bell near the fence to gain access to the facility. The facility staff inside the facility was not answering the phone, which went directly to the fax. Three minutes later, a woman (Staff B) dressed in pajamas unlocked the fence. On at 5:33 am Staff B stated, "I am a staff member of the facility, I am by myself, but the administrator is coming soon.

On at 5:33 am, observed Resident #2 lying in bed awake with a chair and a walker blocking her and a fan directly on her.

On at 6:00 am the Administrator arrived to the facility.

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Interview and observations on at 8:44 am revealed Resident #2's a strong odor resembling . Further observations revealed Resident #2's bed was completely wet.

On at 8:44 am Resident #2 stated, "I am wet in bed, Staff B put the walker and the wheel chair to prevent me from falling from the bed. I cannot get out of bed without help. I am feeling because I am wet and the fan is pointing at me directly." Resident #2 revealed her incontinence brief had not been changed throughout the night.

Observations on at 9:19 am revealed Staff B approached Resident #2, placed the wheel chair at the side of the bed, and moved the rolling walker to assist Resident #2 to come out from the bed. The bed for Resident #2 was totally drenched in and Resident #2. was observed dripping from Resident #2 as she walked with her rolling walker. Staff B reported she changed Resident #2 two times.

Interview on at 9:19 am Staff A stated in an interview, "Could you image! Looked at the time, she has been on bed all this time, so this is the reason she is wet." Staff reported they were busy in the facility with Agency staff since 5:30 am that morning and that is why Resident #2 did not receive any incontinence care and was found drench in .

Record review revealed Resident #2's health assessment dated had a medical history of Parkinson's , which is a progressive of the nervous system that affects movement. Physical limitations included decline of lower extremities. Resident #2's assessment stated that the resident had precautions and required assistance with activities of daily living including transferring. Record review revealed the facility did not have a bed rail order for Resident #2.

Class II

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

Based on observation, record review, and interview the facility failed to follow the correct procedure outlined by the state when assisting with self-administration of medications for two of seven sampled residents (#1 and #3).

Finding included:

Observation on at 7:30 am revealed Staff B put all residents' morning medications were in separate plastic cups on the top of the dining . Further observations on at 8:10 am revealed Staff B took the cup for Resident #3. Then, Staff B poured the pills inside the cup into Resident

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#3's mouth.

Interview on at 8:10 am Staff B stated, "Resident #3 needs assistance with his medications." In addition, interview at 8:20 am Staff B stated," Resident #1 had and she cannot grab the cup or each pill."

Observation on at 8:20 am Staff B again took the cup for Resident #1. Then, Staff B poured the pills inside the cup into Resident #1's mouth.

Record review revealed Residents #1 and #2's health assessment stated the residents needed assistance with self-administration of medication."

Class III

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

Based on observation, record review, and interview the facility's failed to maintain the Medication Observation Records (MORs) of six of seven sampled residents (#s 1, 2, 3, 4, 5 and 7).

Findings included:

1. Observation on at 9:00 am revealed Resident #3 refused to take her medications.

Record review revealed Resident #3's medications observation record was blank.

2. Further observation on at 7:00 am revealed all of the residents' morning medications were in separate plastic cups.

Record review revealed Staff B initialed residents' (2, 3, 4, 5, and 7) morning medications on the MORs.

Interview on at 7:00 am Staff B stated, "It is easier to put the medications inside cups and give their medications."

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, record review, and interview, the facility failed to have a written statement from a

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health care provider documenting that one out of three sampled staff did not have any signs or symptoms of communicable and an evidence of a negative examination documented on an annual basis (Staff B).

Findings included:

at 5:30 AM Staff B was the only staff observed in the facility preparing breakfast, serving breakfast, and assist the residents with self-administration of medications.

Record review of the facility's personnel' files revealed that Staff B, hired on , did not have a written statement from a health care provider documenting that one out of three sampled staff did not have any signs or symptoms of communicable and an evidence of a negative examination documented on an annual basis in file.

During an interview on at 10:28 AM Staff B stated, "I did the test, I have appointment on Wednesday to get the result."

Class III

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

Based on record review and interview the facility who is the payee for one of seven sampled Residents (#6) failed to have a surety bond.

Findings included:

Interview on at 9:00 am Staff A stated the facility was payee for one resident (#6).

Record review revealed the facility did not have an update surety bond in file at the time of the survey. Record review revealed Resident #6 received $750.00 monthly.

Interview on at 9:00 am Staff A stated, "The facility has a surety bond for $5,000.00, but it expired. Staff A stated, "I did a new surety bond, but it has not arrived, yet."

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

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Based on observation and interview, the facility failed to provide a safe living environment free of hazards and also failed to ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.

Findings included:

On at 5:36 AM during the facility's tour, the living was observed to have a peeling couch and dark stain on the ceiling by the AC vent, the kitchen was observed as well to have a dark stain by the AC vent and a crack in the ceiling, roaches were observed crawling on # 's door and on the dining , Resident #1 had a plastic bin by the bed for nightstand, and the backyard was observed to have lots of junk cars' parts, and car tires.

During the exit interview on at 10:50 AM. Staff A acknowledged that the facility had roaches and concerns with the physical plant.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview the facility failed to have an up-to-date admission and discharge log.

Findings included:

Record review revealed that the facility was missing information of one discharged resident (# 11) on the admission/discharged log at the time of the survey. Record review revealed that the facility had no information and/or reason that reflected resident #11 discharged.

Interview on at 9:30 am Staff A stated, "She was here only one day."

Class III

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

Based on interview and record review, the facility failed to submit an adverse incident report to the agency within 1 day and a 15 day full report after the elopement of one of seven sampled residents (#11).

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Findings included:

Interview on at 8:10 am Staff A stated, "I call the police and make a report, and they also told me that they found Resident #11. I did not send a report to AHCA because she was not even a day here. I did not have time to make a record for her. I only have the hospital discharge and some information; I even think that I have too much taking in consideration the time she was living here. Resident # 11 jumped the fence; I have a picture of how she did it."

Record review revealed Resident #11 had a police report with a case #171101419361 (dated on).

Interview on at 7:54 am Resident #11's sister stated, "My sisters was at the hospital. She is not doing well mentally. One day, I call to the hospital, and they told me that my sister was discharged to an ALF. I explained to Staff A that I will find another place for my sister. They call me next day to tell me that my sister escape from the facility. I could not understood how she will jump the fence. It something that I never will believed. The facility did nothing to look for my sister. We went out and the police told us to let them know if we find her first. The police found my sister walking the street. She was missing for a couple of days."

Class III

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0000 - Initial Comments

A Complaint (CCR# 2017015233) Survey was conducted on , 2018 and concluded on , 2018. Villa Esmeralda ALF (license #9978) had deficiencies identified at time of the survey.

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

Based on record review and interview the facility failed to have a medical examination completed within 30 days of admission for one of seven sampled residents (Resident #5).

Findings included:

Record review revealed the admission /discharge log had Resident #5, who was admitted on .

Record review revealed Resident #5 did not have a health assessment in her file.

Interview on at 9:00 am Staff A stated, "The doctor will be here soon to see her."

Class III

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

Based on interview and record review the facility failed to have documentation for one of seven sampled residents (#7) who refused to take medications for almost a month. The facility also failed did not have any documentation that the doctor was informed that Resident #7 was not taking medications.

Findings included:

According to Staff A and B on at 7:31 am, "Resident #7 used to take all her medications daily; however, Resident #7 is refusing to take the medication, and we cannot force her to take her medications."

Record review revealed Resident #7's medication observation records (MORs) did not have written information or explanation why Resident #7 is not taking medications for almost a month. The facility failed to have written documentation regarding Resident #7 who was not taking medications. The facility also failed to contact the doctor to report a change in Resident #7's condition. Resident #7's health assessment dated had a diagnoses of , and .

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Class III

0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC

Based on observation and interview, the facility failed to encourage the residents to participate in social, recreational, educational and other activities within the facility and the community.

Findings included:

On at 10:00 AM Resident #3 and #5 were observed sitting in the living TV. Resident #1, 2, 4, and 7 were in their .

During an interview on at 8:14 AM, Resident #5 stated "I only watch TV here."

On at 8:27 AM Resident #3 stated "there are no activities here, we watch TV that's it."

Class III

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

Based on observation, record review, and interview, the facility failed to treat one of seven sampled residents with dignity and respect (Resident #2. The resident was found in bed drenched in , and the facility used a wheelchair and rolling walker as a physical to keep the resident in bed.

Findings included:

On at 5:30 am Agency staff arrived to the facility. The facility's fence was locked, the facility did not have a door bell near the fence to gain access to the facility. The facility staff inside the facility was not answering the phone, which went directly to the fax. Three minutes later, a woman (Staff B) dressed in pajamas unlocked the fence. On at 5:33 am Staff B stated, "I am a staff member of the facility, I am by myself, but the administrator is coming soon.

On at 5:33 am, observed Resident #2 lying in bed awake with a chair and a walker blocking her and a fan directly on her.

On at 6:00 am the Administrator arrived to the facility.

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Interview and observations on at 8:44 am revealed Resident #2's a strong odor resembling . Further observations revealed Resident #2's bed was completely wet.

On at 8:44 am Resident #2 stated, "I am wet in bed, Staff B put the walker and the wheel chair to prevent me from falling from the bed. I cannot get out of bed without help. I am feeling because I am wet and the fan is pointing at me directly." Resident #2 revealed her incontinence brief had not been changed throughout the night.

Observations on at 9:19 am revealed Staff B approached Resident #2, placed the wheel chair at the side of the bed, and moved the rolling walker to assist Resident #2 to come out from the bed. The bed for Resident #2 was totally drenched in and Resident #2. was observed dripping from Resident #2 as she walked with her rolling walker. Staff B reported she changed Resident #2 two times.

Interview on at 9:19 am Staff A stated in an interview, "Could you image! Looked at the time, she has been on bed all this time, so this is the reason she is wet." Staff reported they were busy in the facility with Agency staff since 5:30 am that morning and that is why Resident #2 did not receive any incontinence care and was found drench in .

Record review revealed Resident #2's health assessment dated had a medical history of Parkinson's , which is a progressive of the nervous system that affects movement. Physical limitations included decline of lower extremities. Resident #2's assessment stated that the resident had precautions and required assistance with activities of daily living including transferring. Record review revealed the facility did not have a bed rail order for Resident #2.

Class II

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

Based on observation, record review, and interview the facility failed to follow the correct procedure outlined by the state when assisting with self-administration of medications for two of seven sampled residents (#1 and #3).

Finding included:

Observation on at 7:30 am revealed Staff B put all residents' morning medications were in separate plastic cups on the top of the dining . Further observations on at 8:10 am revealed Staff B took the cup for Resident #3. Then, Staff B poured the pills inside the cup into Resident

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#3's mouth.

Interview on at 8:10 am Staff B stated, "Resident #3 needs assistance with his medications." In addition, interview at 8:20 am Staff B stated," Resident #1 had and she cannot grab the cup or each pill."

Observation on at 8:20 am Staff B again took the cup for Resident #1. Then, Staff B poured the pills inside the cup into Resident #1's mouth.

Record review revealed Residents #1 and #2's health assessment stated the residents needed assistance with self-administration of medication."

Class III

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

Based on observation, record review, and interview the facility's failed to maintain the Medication Observation Records (MORs) of six of seven sampled residents (#s 1, 2, 3, 4, 5 and 7).

Findings included:

1. Observation on at 9:00 am revealed Resident #3 refused to take her medications.

Record review revealed Resident #3's medications observation record was blank.

2. Further observation on at 7:00 am revealed all of the residents' morning medications were in separate plastic cups.

Record review revealed Staff B initialed residents' (2, 3, 4, 5, and 7) morning medications on the MORs.

Interview on at 7:00 am Staff B stated, "It is easier to put the medications inside cups and give their medications."

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on observation, record review, and interview, the facility failed to have a written statement from a

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health care provider documenting that one out of three sampled staff did not have any signs or symptoms of communicable and an evidence of a negative examination documented on an annual basis (Staff B).

Findings included:

at 5:30 AM Staff B was the only staff observed in the facility preparing breakfast, serving breakfast, and assist the residents with self-administration of medications.

Record review of the facility's personnel' files revealed that Staff B, hired on , did not have a written statement from a health care provider documenting that one out of three sampled staff did not have any signs or symptoms of communicable and an evidence of a negative examination documented on an annual basis in file.

During an interview on at 10:28 AM Staff B stated, "I did the test, I have appointment on Wednesday to get the result."

Class III

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

Based on record review and interview the facility who is the payee for one of seven sampled Residents (#6) failed to have a surety bond.

Findings included:

Interview on at 9:00 am Staff A stated the facility was payee for one resident (#6).

Record review revealed the facility did not have an update surety bond in file at the time of the survey. Record review revealed Resident #6 received $750.00 monthly.

Interview on at 9:00 am Staff A stated, "The facility has a surety bond for $5,000.00, but it expired. Staff A stated, "I did a new surety bond, but it has not arrived, yet."

Class III

0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC

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Based on observation and interview, the facility failed to provide a safe living environment free of hazards and also failed to ensure that all existing architectural, mechanical, electrical and structural systems, and appurtenances are maintained in good working order.

Findings included:

On at 5:36 AM during the facility's tour, the living was observed to have a peeling couch and dark stain on the ceiling by the AC vent, the kitchen was observed as well to have a dark stain by the AC vent and a crack in the ceiling, roaches were observed crawling on # 's door and on the dining , Resident #1 had a plastic bin by the bed for nightstand, and the backyard was observed to have lots of junk cars' parts, and car tires.

During the exit interview on at 10:50 AM. Staff A acknowledged that the facility had roaches and concerns with the physical plant.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview the facility failed to have an up-to-date admission and discharge log.

Findings included:

Record review revealed that the facility was missing information of one discharged resident (# 11) on the admission/discharged log at the time of the survey. Record review revealed that the facility had no information and/or reason that reflected resident #11 discharged.

Interview on at 9:30 am Staff A stated, "She was here only one day."

Class III

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

Based on interview and record review, the facility failed to submit an adverse incident report to the agency within 1 day and a 15 day full report after the elopement of one of seven sampled residents (#11).

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Findings included:

Interview on at 8:10 am Staff A stated, "I call the police and make a report, and they also told me that they found Resident #11. I did not send a report to AHCA because she was not even a day here. I did not have time to make a record for her. I only have the hospital discharge and some information; I even think that I have too much taking in consideration the time she was living here. Resident # 11 jumped the fence; I have a picture of how she did it."

Record review revealed Resident #11 had a police report with a case #171101419361 (dated on).

Interview on at 7:54 am Resident #11's sister stated, "My sisters was at the hospital. She is not doing well mentally. One day, I call to the hospital, and they told me that my sister was discharged to an ALF. I explained to Staff A that I will find another place for my sister. They call me next day to tell me that my sister escape from the facility. I could not understood how she will jump the fence. It something that I never will believed. The facility did nothing to look for my sister. We went out and the police told us to let them know if we find her first. The police found my sister walking the street. She was missing for a couple of days."

Class III

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Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, record review, and interview the facility failed to obtain a licensure capacity increase prior to providing personal care, meals, and assistance with self- administration of medication for seven of seven residents (#s 1-7).

Findings included:

Observation on at 5:32 am revealed Resident #3 was sleeping in the to the facility's office. Further observations revealed the facility had nine beds in the facility at time of survey. Observation on at 6:40 am revealed there were medications in the storage cabinet which belonged to Residents 1-7.

Record review revealed Resident #3 was admitted on with an Adult Day Care agreement on to drop him off at 7:00 am and picked him up at 8:00 pm with a monthly payment of $735.00. Resident #7 also had a residency agreement with the facility dated on for $733.00 monthly.

Review of Resident #3's Medication Observation Record (MOR) reflected daily medication signed by the facility's staff. The admission/discharged log had seven residents listed.

Interview on at 6:30 am Staff A stated, "We have six residents, however, Resident #3 is a charity. We do not have a benefits, and he has not paid for years. I cannot take him out of here; I could not do that."

Interview on at 8:44 am Resident #2 stated, "I live in this Resident #1. We are seven residents. Resident #6 is at the hospital."

Interview on at 8:49 am Resident #4 stated, "I have been living here for two years. We are seven including Resident #6 (hospital). I have my three meals and medications daily; I see my doctor monthly. I sleep at the to the office. I also must to work in the facility to pay part of my services because I am not receiving government financial assistance."

Unclassified