| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11911702** | **02/22/2018** |
| NAME OF PROVIDER OR SUPPLIER **VICTORIA'S RETIREMENT HOME** | STREET ADDRESS, CITY, STATE, ZIP CODE **2233 NW 56TH AVENUE LAUDERHILL, FL 33313** | |

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

**0000 - Initial Comments**

An unannounced Relicensure survey was conducted on - at Victoria's Retirement Home, Assisted Living Facility, License # 4973.
The facility had deficiencies at the time of the visit.

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

Based on record review and interview, the facility failed to report to the Health Care Provider that the Resident was away from the facility on a consistent basis at the time that the medication was ordered for 1 of 4 sampled residents reviewed (Resident # 5).

The findings included:

On , a review of the Medication Observation Record (MOR) for Resident # 5 reveals the resident was admitted to the facility on . On , a review of the resident's Medication Observation Record (MOR) dated revealed Resident #5 receives the following medications: LACE CRE 12% twice daily, , 1 mg. (milligram) tablet daily, , 0.5 mg. 1 tablet 7:00 AM and 12:00 PM, , 500 mg. 1 tablet twice daily, 1 tablet 20 mg. at bedtime, Haloper 150 mg, inject every 4 weeks, capsule 300 mg. twice a day, 500 mg. 7:00 AM with a meal, Clanzapine 1 tablet 10 mg, 7:00 AM, (Discontinue ), Clonazapine 1 tablet 20 mg. at 7:00 AM, (Discontinue ), Propanzalol 2 tablets 20 mg. 7:00 AM, 12:00 PM and 5:00 PM and 0.1 %, apply twice daily, 7:00 AM and 5:00 PM.
The following medications were ordered effective : , 30 mg. 1 tablet at bedtime 8:20 PM, , 1 mg. 1 tablet twice daily 7:00 AM and 5:00 PM and , 2 mg. at 7:00 AM and 5:00 PM.
On a further review of the MOR reveals the resident did not receive their medication on the following dates: 5:00 PM medications, (Out of facility), 12:00 PM medications (Refused medications, 12:00 PM ... (type of medication) medication (Refused) and 7:00 AM , 20 mg.. 7:00 AM, (Refused).
A review of the progress notes reveals no evidence of documentation that that the Medication Technicians notified the resident's physician regarding the resident either refusing to take their medications or being out of the facility at the time that the dosages were prescribed. On at 02:00 PM, an interview was conducted with Staff A who stated she was not aware that she was to call the resident's physician regarding the resident refusing to take their medications or being out of the facility. On at 02:00 PM, an interview was conducted with the Administrator who

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

acknowledged the findings.

Class III

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

Based on record review and interview, the facility failed to ensure that Staff obtain a current statement documenting a negative examination, for 1 of 4 sampled employees ( Staff C).

The findings included:

On , a review of the facility's employee personnel records was conducted to reveal Staff C, who works as a Home Health Aide (HHA) was hired on . Further review reveals no evidence of documentation of an annual statement documenting a negative examination. Continued review reveals that Staff C works as a direct care staff member. On at 02:00 PM, an interview was conducted with the Administrator who acknowledged the fining.

Class III

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

Based on observation and interview, the facility failed to provide a clean and safe living environment,

The findings included:

Observation, on at 10:00 AM, during a tour of the facility reveals that the facility consists of Building #1 and Building #2 and reveals in Building #1- # , has a double dresser with scratched and peeling paint on the wood; Patio chairs have peeling paint and gray matter on the wicker chairs; # had a yellow stained plastic chair seat, soaked with a smelling liquid; Walls in building #1 had peeling paint and chairs in Building #1 had peeling paint and scratches on the wood.
Observation, on at 10:00 AM, during a tour of the facility reveals in Building #2 that a resident's is covered with fecal like material. On at 10:30 a.m., the observations were shown to the Administrator and during an interview, on at 10:30 a.m., the Administrator acknowledged the findings.

Class III