STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	04/03/2018
NAME OF PROVIDER OR SUPPLIER **VICTORIA VILLA**	STREET ADDRESS, CITY, STATE, ZIP CODE **5151 S.W. 61 AVENUE** **DAVIE, FL 33314**	

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2018001356 was conducted on [redacted] at Victoria Villa, License # 8646. The facility had deficiencies at the time of the survey.

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

Based on observation, interview and record review the facility failed to meet continued residency requirements for 5 out of 5 residents (Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5).

The findings include:

During the lunch hour between12:30 PM and 1:30 PM observations revealed total transfers of Resident #1, Resident #2, Resident #3, Resident #4 and Resident #5. Staff members were observed lifting residents and positioning wheelchairs for residents to be seated in. Residents at this time of observation did not demonstrate any type of willingness/ability to assist during the transfer, residents were fully dependent on staff members to get them up out of the reclining chairs to the chairs into the [redacted] from the lunch [redacted] back to the chairs in the activity [redacted].

Resident #1 at 12:55 PM was observed around the table with her eyes closed and being fed by Staff D. It was the resident birthday and family members were gathered around to celebrate, family could be heard encouraging her to open her eyes and speaking to her. At this time Staff B was asked on [redacted] at 12:58 PM, if she could feed herself on any other day or if she would try to feed herself. Staff B stated no she is not able to, we have to feed her breakfast, lunch and dinner.

During an interview with Staff B on [redacted] during the lunch hours between 12:30 PM and 1:30 PM revealed multiple residents needed 2-person transfer. During this interview and observation of observing staff members transfer residents from dining [redacted] activity [redacted], she informed that a few residents in the facility were total care, mostly the residents who have resided at the facility for a while. Staff B was asked for the names of the residents she believed was total care and not on hospice. Staff B stated that Resident #1, Resident #4 and Resident #5 were all total care. Staff B further stated that Resident #4 family members did not want her to be on hospice and that she was previously on hospice but no longer qualified for hospice services and was dismissed from the program. During this time of observation Staff B was also questioned about Resident #3, Resident #6 and Resident #7, observation of these residents revealed residents were being lifted from dining to activity activity dining [redacted]. Staff B seemed unsure and went to ask for clarification on patient status. At this time 5 of 7

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resident files were requested for review.

During a brief confidential interview on , it was stated that the residents are not able to transfer and cannot be lifted by just one person, two staff member work together to put them in the wheelchair safely. Some staff members were observed breathing excessively hard and made comments about their back hurting due to the requirement of lifting so many residents.

Record review of 5 out of 7 sampled residents confirmed the findings of surveyor observation and interviews. Record review revealed that 5 out of 5 residents were totaled in one or more Activity of Daily Living and was not receiving hospice services:

1. AHCA Health Assessment 1823 dated revealed Resident #1 was admitted to the facility on with a diagnosis of , and . According to the doctors evaluation Resident #1 was total with the following Activities of Daily Living and required special diet instruction of a pureed diet.
2. AHCA Health Assessment 1823 dated revealed Resident #2 was admitted to the facility on with a diagnosis of , , , II, , , Mixed , , . According to the doctors evaluation Resident #2 was total with the following Activities of daily living self-care ( ).
3. AHCA Health Assessment 1823 dated revealed Resident #3 was admitted to the facility on with a diagnosis of , , , Gait Disturbance and . According to the doctors evaluation Resident #3 was total with Ambulation, Dressing, Eating and Self Care ( ) and required special diet instruction of a pureed diet.
4. AHCA Health Assessment 1823 dated revealed Resident #4 was admitted to the facility on with a diagnosis of , , , , and . According to the doctors evaluation Resident #4 was total with the following Activities of daily living Bathing, Dressing, Eating, Self-care ( ) and toileting required special diet instruction of a pureed diet with thicken liquids.
5. AHCA Health Assessment 1823 dated revealed Resident #5 was admitted to the facility on with a diagnosis of , , and , , , . According to the doctors evaluation Resident #5 was total with the following Activities of daily living Bathing, Dressing, transferring, Self-care ( ) and toileting.

Further record review and interview with the Administrator, revealed none of the residents are receiving and/or enrolled in Hospice.

On at 5:35 PM , an interview was conducted with Staff A (Administrator), Staff B (DON) and

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Staff C (Administrative Assistant) informing them that during activities and lunch observations was noted that many of the residents required total assistance with ambulation and transfer. During subsequent interviews with Staff B and confidential interviews with staff members, it was also noted that a few of the residents required total care from staff members and that most residents have aged in place. They were advised at this time that a sample of 5 AHCA Health Assessment 1823 were reviewed and confirmed the surveyor observation of residents inappropriate for continued residency. They were advised that if resident are not receiving hospice services and is total with any areas of ADL's the resident is deemed inappropriate for an assisted living facility. The Administrator and staff confirmed the findings and provided no further explanation at this time.

Class III

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

Based on interview, record review and observation the facility failed to honor residents rights due to having bedrails placed on 5 of 5 sampled residents beds.

During a tour conducted on . . . . . at 8:10 AM with Staff D, the following was revealed:

. . - Resident #3, Bed C had full bed rails and a night stand used as a . . . . , Staff D at this time confirmed that resident cannot function the bedrails and cannot push the night stand away from her bed.

- Bed A - full bed rails and night stand used as a to backup the bedrails, Staff D at this time confirmed that resident cannot function the bedrails and cannot push the night stand away from her bed.

- Resident #5 - Half bed rails observed, and night stand used as a to backup the bedrails. Staff D confirmed that resident cannot function the bedrails and push the night stand away from her bed.

had 3 beds inside but only two residents were in the bed, the other resident was sleeping on a cushion mat on the floor. When Staff D was questioned about why the resident was sleeping on the floor she stated the resident was a risk.

detail observations -

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Bed A - Resident #8 - night stand being used as a . . . . pushed up against the resident bed, Staff D confirmed that resident cannot function the bedrails and push the night stand away from her bed.

Bed B - Resident #9 - 2 half bed rails with a night stand also pushed up against the bed rails, Staff D confirmed that resident cannot function the bedrails and push the night stand away from her bed.

Bed C - Resident #10 - Resident was not in bed; the resident was observed sleeping on the floor.

An interview was conducted with Staff A, Staff B and Staff C regarding the findings of the bed rails and night stands. Staff A (Administrator) admitted that she knows the overnight staff push the night stands against the bedrails and/or against the resident bed. She further questioned how could she protect them. She stated she did not know she couldn't use nightstands to protect them from getting out of bed. She admitted that residents are not able to get in and out of the bed when the night stands are pushed up against the rails and/or if they have the nights stands pushed up against the resident bed.

An interview was conducted with Staff D regarding night stands and residents observed with bed rails. Staff D stated residents are not able to push the nightstands and cant get out of the bed with the rails ups, she stated the residents have . . . . . and don't know how to maneuver the rails, that the rails are there for safety. At this time she also stated that the overnight staff push the night stand up to the bed rails but they are not supposed to be moving the night stands.

Record review determined there was no consent given for residents to have consent for bed rails. Upon record review, no residents had bed rails orders located inside of their files. Bed rail orders were requested from Staff A (Administrator) and Staff B (DON) and they were unable to provide bedrail consent from physicians and/or family members regarding bedrails and proper use of . One bedrail order was provided for Resident #8 who did not have bedrails on her bed.