STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968273	05/31/2018
NAME OF PROVIDER OR SUPPLIER **VILLA LINDA INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **670 W 72ND PL** **HIALEAH, FL 33014**	

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

0000 - Initial Comments

A Standard Biennial survey was conducted on and concluded on . Villa Linda Inc, with Limited Mental Health component, license number 12258, had deficiencies found at the time of the survey.

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

Based on observation, record review, and interview, the facility failed to ensure that one of six sampled residents that was discharged from the hospital with a , received care by licensed skilled professionals. Resident #1 did not have an order for care, unlicensed staff members in the home were only apply Mupuricin to the . The facility also failed to have updated records for Resident #1 including written notes and an assessment.

Findings included:

Interview on at 8:30 am Staff B and D stated they took some time to answer the door earlier because the staff members were providing care to Resident #1. They stated, "Resident #1 has an because he went to the hospital recently, and he came back with a little at the lower back. We applied Mupuricin and a gauze." Staff B and D revealed, "We are not licensed nurses, we are caretakers."

Interview on at 8:35 am Staff D stated, "Resident #1 went to the hospital because he was refusing to take his medications, he was aggressive and he was saying that he wanted to get out." In addition, she stated, " He went to the hospital the 5th or 10th of this month (, 2018)."

Record review revealed Resident #1's discharge hospital documents from stated, " . Sacral , on b/l upper and lower extremities poor ."

Observation on at 8:41 am revealed that Resident #1 was sitting on a shower chair and Staff B moved the chair to the TV area to sit Resident #1 in a recliner. Resident #1 could not stand firm on his feet; therefore, Staff B and D transferred him to the chair by lifting him.

The facility failed to have an updated health assessment for Resident #1 after the resident was discharged from the hospital with a . Resident #1's health assessment dated on documented Resident #1 had a diagnosis of , high , , Atherosclerotic - , Prostatic Hyperplasia, Parkinson, and . The health

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assessment reflected that Resident #1 needed assistance with self-administration of medications and with activities of daily living.

Resident #1's progress notes on stated, " Resident #1 was hospitalized on ... because he was aggressive, altered, refused to eat and take medication." The facility did not have any further information documented after the admission to the hospital or discharge from the hospital.

Interview on at 11:10 am, Resident #1's family member stated, "I am aware that Resident #1 has an on his sacrum area and his heels. However, I was not aware that a nurse was not taking care of it."

Interview on at 11:30 am Staff A stated, "Resident #1 came with a little on his sacrum area, and we are taking care of it. He is not under any home health care. However, it is a small , and he saw his doctor. We are putting the cream on it."

Phone interview on at 8:00 am Staff A stated, "I will take Resident #1 to the doctor to examine his ; however, it looks okay. I will send the information from the doctor."

Record review revealed that Resident #1 had a doctor order dated on that stated, "Nursing skill/ care daily with diagnosis of Sacral ." Therefore, Resident #1 was living in the facility with a Sacral with no professional care from of a license Nurse from -

Record review revealed that Resident #1 had a Nurse assessment (home health) with certification from - . The plan of care's principal diagnosis stated, " of Sacral region, ."

Class II

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

Based on observation, record review, and interview the facility failed to ensure that licensed staff administered medications to one of six (#1) sampled residents.

Findings included:

Medication pass observations on at 8:41 am revealed Staff D removed the medications from

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Resident #1 labeled bin. Staff D poured medications in container to crush the medications. Then, Staff D poured the crushed medication in the dry cereal and fed Resident #1 the medications.

Interview on at 8:41 am Staff D stated, "I have to give the medications directly to the mouth with the spoon, and I poured on the cereal because he would refused to take it without it."

Record review revealed Resident #1's medication observation record reflected the following medications at 8:00 am:

81 mg
SOD 100 MG
0.5 mg
100 MG
Ankiduoube BES 5 mg
-Levo 25-100 mg

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 decent living environment.

Findings included:

Observation on at 8:00 am revealed stains on the ceiling at the kitchen area. The Florida an unfinished portion on the ceiling, and the toilet's bottom border were stained in #. The backyard had seven chairs, a sofa, and two rocket chairs that were worn.

Interview on at 10:30 am Staff A stated that the facility will have renovations and she will change everything.

Class III

0181 - Emergency Plan Approval - 58A-5.026(2) FAC

Based on record review and interview the facility failed to have the emergency management plan reviewed annually.

Findings included:

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The emergency management plan posted on board was dated . . . . . Record review revealed the facility did not have a copy of the emergency management plan approval in the facility at time of survey.

Interview on at 12:00 pm Staff A confirmed that the Emergency Management Plan posted on board was not update. In addition, Staff A stated, "This application was already done and submitted, but I did not receive the approval letter, yet."

Class III