STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966453	**09/05/2018**
NAME OF PROVIDER OR SUPPLIER **VICTORIA GARDEN ALF INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **3091 NW 43RD STREET** **LAUDERDALE LAKES, FL 33309**	

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

0000 - Initial Comments

An unannounced Relicensure survey was conducted on . . . . . at Victoria Garden ALF Inc., License #10631. The facility had deficiencies at the time of the survey.

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

Based on observation, record review, and interview the facility failed to provide a safe, clean living environment maintained free of hazards for all sampled residents residing at the facility.

The findings included:

While touring the facility on . . . . . between the times of 10:00 AM and 11:00 AM, the following was observed:

a) -Observations of the wall in the a large grey stain on a white wall. Additional observations revealed chipped paint of the wall outside of the gray area in front of the resident bed where a headboard would be located. During an interview with Resident #3 on at 10:22 AM regarding the stain on the wall, it was stated that the stain was there prior to his arrival, and that the staff knows that the stain is there and have done nothing about it.

b) located near the dining a bathtub with brown and yellow grime observed at the bottom of the bathtub that resembled dirt residue. On top of the grime was a red bathtub mat and a white shower chair observed on top of the mat. The a shared is used by Residents in . . . , ... , residents in the dining . . . . . guest that visit residents at the facility. Upon questioning the staff in regards to the shower chair the Staff was unable to state who the shower chair belonged to or why the . . . . . not been cleaned. Further observations of the . . . random steaks of brown paint and a gray colored substance on the white tiled wall that when touched does not rub off. Observations of the soap dispenser for handwashing revealed no soap or paper towels for hand drying.

During an interview with the Administrator at 10:34 AM on , the findings were discussed and acknowledged. No further information was provided for review.

Class III

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

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on observation, interview and record review, the facility failed to provide, within 1 business day, an Adverse Incident Report to the Agency for Health Care Administration (AHCA) related to an event that was reported to law enforcement that resulted in the of a Resident, for 1 of 2 sampled residents at the facility (Resident #8).

The findings included:

While waiting on the Administrator to arrive at the facility at 9:50 AM on , the facility's bulletin board was observed with the menus, the staffing schedule, the Department Of Health inspection reports, and the fire inspection. Further observations revealed a photo of Resident #8 that stated rest in peace with no observed date on the photo. Upon the Administrators arrival at 10:00 AM the resident's photo was taken down, the Entrance Conference was conducted and a tour of the facility began.

During an interview with the Administrator at 10:15 AM regarding the resident (Reisdent #8)posted on the board it was stated that the facility had a resident that went out for a walk, than got hit by a truck and was killed. When questioning the date that the incident occurred It was stated a few weeks ago.

During an interview with Resident #3 at 10:22 AM on regarding the environment at the facility it was stated by Resident #3 that he was getting a new soon because his previous one was hit by a truck and . It was further stated by Resident #3 that Resident #8 was walking to the gas station up the road very early one morning when he was hit, and that the accident happened about three weeks prior.

During an additional interview with the Administrator at 11:00 AM on the adverse report was requested. It was stated that an adverse incident was not completed because there was nothing the facility could have done to prevent the incident. It was stated that Resident #8 went for a walk after breakfast as usual and he was hit by a truck, I guess the truck didn't see him.

At 3:10 pm on , a copy of the incident report was requested from the Administrator. During this time, the Administrator stated that she didn't get one and that the police came and stated that he got hit by a truck and it was an accident and he gave me this card. The card was reviewed for the name of the officer and the police department involved.

Record review of the file for Resident #8 revealed an AHCA 1823 form dated for that documented that the resident independent with all Activities of Daily Living (ADL's) and not documented as being an elopement risk. Review of the medical history and diagnosis revealed the resident has mild , and an unidentified psych diagnosis.

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Further review of the file revealed an additional AHCA 1823 form dated for that revealed that Resident #8 has a medical history and diagnosis of , , and a and behavioral status of , judgement. Under the section labeled special precautions it is documented that the resident needs routine supervision.

During an interview with Staff C, at 1:24 pm on , it was stated that Resident #8 is a person that wakes up early and is usually up walking around. Sometimes he goes out and he begs people for money to go to the corner store and sometimes he has headphones that he wears, he never hear people when they are on if you are calling him. It was further stated that maybe he had them on that morning and when the truck came he didn't hear it coming. It was stated that everyone goes to the store down the street, he goes often sometimes a few times a day no one wouldn't think anything of it.

The local news report was pulled for that was reported from the local Sherriff's office. It was revealed that Resident #8 was hit while walking across the road at 5:40 AM in the morning prior sunrise. During an interview with the Administrator previously on at 11:00 AM, it was stated that Resident #8 went for a walk after breakfast as usual when the incident occurred. Review of the meal times posted on the facility's bulletin board on the date of the survey revealed that breakfast is served between the times of 6:00 AM and 7:00 AM daily, and that the incident occurred prior to breakfast, making the resident taking a walk outside of the usual time frame known to facility staff.

During an interview with the Administrator at 5:34 PM on , she was informed that an adverse incident should have been completed due to the of a resident that occurred under the supervision of the facility for a resident that required more supervision than what the facility was providing. The Administrator was also informed that the facility is not secured and that the resident has a diagnosis of on the AHCA 1823 form. The Administrator was further informed that law enforcement was involved and a copy of the police report or the hospital records were never obtained. Review of the progress notes for Resident #8 revealed the resident expired at the Hospital the same day the incident occurred. The progress notes and Resident #8's AHCA 1823 forms were handed to the Administrator to review. The Administrator acknowledged the findings and provided no further documentation for review.

Class III