STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968031	**11/29/2018**
NAME OF PROVIDER OR SUPPLIER **VILLA ROSE ASSISTED LIVING INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **4231 SW 58TH AVE** **MIAMI, FL 33155**	

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

0000 - Initial Comments

A Standard Biennial Survey was conducted on 11/29/18. Villa Rose Assisted Living Inc. had deficiencies identified at the time of the survey.

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

Based on observation, record review, and interview, the facility failed to conduct as part of the continued residency criteria for its residents a -to- medical examination by a health care provider after a significant change for one out of 7 sampled residents (Resident #3).

Findings included:

On at 8:35 AM observed Staff C feeding Resident #3 a toast. The resident had difficulties swallowing and feeding herself the toast. Further observation revealed from 9:07 AM to 9:32 AM Staff C putting medication one by one in Resident #3's . Resident #3 had difficulties swallowing the medications. Resident #3 made some medication melt in her with water, then swallowed with a lot of water. Resident #3 spitted out the medications she couldn't chew and swallowed.

A review of Resident #3's record on revealed that the health assessment dated revealed that the resident medical history and diagnosis were: ( ), , , , ( ), (OA), , , and ( ). The recommended diet was no added salt and low fat/low . Resident #3 needed assistance with and supervision with ambulation, bathing, eating, grooming, toileting, and transferring. Further review showed progress notes dated stated "Resident today show to be quiet, alert at times, she uses , have order of puree, medications are sup by care taker."

During an interview on around 3:20 PM, the Administrator acknowledged and stated "I am going to call the doctor when I finish with you."

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC 429.255(1)(b). FS

Based on record review and interview, the facility failed to ensure that hospice documentation was in the facility for services provided to two out of seven sampled residents (Resident #1 and #2).

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Findings included:

A review of Resident #1' file on //18 revealed that the residents' last three hospice plan of care were dated , , and . Further review showed the last three hospice plan of care for Resident #2 were , , and .

During an interview on at 3:20 PM, the Administrator acknowledged the findings and stated "Resident #2 is going to be discharged from hospice on Monday I think."

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation and interview, the facility failed to follow the correct procedures outlined by the state when assisting two out of seven sampled residents (#2 and #3) with self-administration of medications.

Findings included:

Observations on at 8:00 AM found Staff C went to Resident #2, who was sitting at the dining table with a cup of water, a medication cup, the Medication Observation Record (MOR), the packs, and a pen. Staff C read the medication and punched the pack one by one and signed the MOR after each time the resident swallowed a medication.

A review of the MOR on revealed that Staff C did not sign off for , - , 25-100 mg tablet (take tablet by daily), Mapap 650 mg CPLT (take 1 caplet by 2 times a day), and 20 mg tablet (take 1 tablet by daily) given to Resident #2.

Further observation on at 9:07 AM showed Staff C placed a cup of water, the medication cup, the packs, and the MOR on the dining room table. Staff C read the medication and punched the medication in a cup, placed it in Resident #3 , then placed the cup of water in the resident . The resident spitted out the medication which on the resident's left arm. Staff C did not notice. Staff C placed all medications one by one in the resident . At 9:19 AM observed Staff C placed , in Resident #3's . The resident hold the medication in her , then spitted it out. The medication rolled on the floor. At 9:24 AM observed Staff C worn gloves, picked the medication up and placed it in the small medication cup. Staff C grabbed another medication cup,

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SUMMARY STATEMENT OF DEFICIENCIES
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punched the labeled and placed in the resident . Then signed off R on the medication record sheet for , SOD DR 40 mg tablet (take 1 tablet by daily).

In an interview on at 9:43 AM, the Administrator Acknowledged the findings and stated "I already told the consultant to send the lady to retrain the staff even though I know they know what to do . They are nervous."

Class III

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

Based on observations and record review, the facility failed to ensure that a licensed personnel administer medications to one out of seven sampled residents (Resident #3).

Findings included:

On at 9:07 AM observed unlicensed Staff C placed a cup of water, the medication cup, the packs, and the Medication Observation Record (MOR) on the dining room table. Staff C read the medication and punched the medication in a cup, placed it in the resident , then placed the cup of water in the resident . Staff C placed all the medications one by one in the resident .

Medication reconciliation on revealed that the medications were:
- SOD 100 mg Capsule, take 1 tablet by daily
- , 0.5 mg tablet, take 1 tablet by in the morning
- , SOD DR 40 mg tablet, take 1 tablet by daily
- , 10 mg tablet, take 1 tablet by daily
-Donezepil 10 mg, take 1 tablet by daily
- , FUM 100 mg Tablet, take 1 tablet by 3 times a day
- 600 mg + Vita D 400 mg tablet, take 1 tablet by daily

Class III

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

Based on observation, record review, and interview, the facility failed to maintain an accurate daily medication observation record (MOR) for two out of seven sampled residents who received assistance with self-administration of medications (Resident #2 and #3).

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

Findings included:

A) On at 8:00 AM observed Staff C providing assistance with self-administration of medication to Resident #2 who was sitting the dining table. Staff C placed a cup of water, a medication cup, the MOR, the packs, and a pen on the table. Staff C read the medication and punched the pack one by one and signed the MOR after each time the resident swallowed a medication.

A review of the MOR on revealed that Staff C did not sign off for , - , 25-100 mg tablet (take tablet by daily), Mapap 650 mg CPLT (take 1 caplet by 2 times a day), and 20 mg tablet (take 1 tablet by daily) given to Resident #2.

B) At 9:19 AM observed Staff C placed , in Resident #3's . The resident hold the medication in her , then spitted it out. The medication rolled on the floor.

A Review of the MOR on revealed that Staff C did not sign off for , FUM 100 mg Tablet and signed off the letter "R" on the medication record sheet for , SOD DR 40 mg tablet (take 1 tablet by daily).

In an interview on at 9:43 AM, the Administrator Acknowledged the findings and stated "I already told the consultant to send the lady to retrain the staff even though I know they know what to do. They are nervous."

Class III

0077 - Staffing Standards - Administrators - 429.176 FS; 429.52( ),58A-5.019(1) FAC

Based on record review and interview, the facility's owner failed to notify the agency of a change of administrator within 10 days of the change. Also, the facility's Administrator who operates three facilities failed to appoint in writing a separate manager for each facility. The facility's assistant administrator failed to keep a copy of the CORE training card and the certificate of the Core training at the facility. The facility also failed to maintain documentation of the facility's assistant administrator high school diploma onsite.

Findings included:

Review of the background screening database revealed that the facility had a new Administrator listed

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on its roster effective as 11/01/18 and an assistant administrator as of . . . . . Further review revealed that the facility's administrator operated three facilities.

Record review on . . . . . showed that there was no letter at the facility written by the Administrator appointing Staff E as the assistant administrator. Further review of the facility's personnel files showed was no copy of the core card and the certificate of the Core training at the facility for the assistant administrator hired on .

In an interview on at 3:36 PM, the Administrator stated "I am the administrator of three places here, and two other facilities. I had an another administrator here and she just left." The Administrator added "Staff E is a nurse. I thought I have the nursing license here."

Class III

0085 - Training - Nutrition & Food Service - 58A-5.0191(7) FAC

Based on record review and interview, the facility failed to ensure that two out of five sampled staff received a minimum of 2 hours of 2 hours continuing education in topics pertinent to nutrition and food service.

Findings included:

A review of the facility's personnel files on . . . . showed that it did not have documentation of a 2 hours training certificate on Nutrition and food service for Staff A hired on . . . . and Staff E hired on . . . . . .

In an interview on . . . . at 3:36 PM, the Administrator stated "I sent the roster to the dietician, we all supposed to have it."

Class III

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