STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964590	**01/10/2019**
NAME OF PROVIDER OR SUPPLIER **VILLA MARGO**	STREET ADDRESS, CITY, STATE, ZIP CODE **2978 SW 27 LANE** **MIAMI, FL 33133**	

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

0000 - Initial Comments

A Complaint (CCR #2018016984) survey was conducted on and concluded on . Villa Margo had the following deficiencies identified at time of the survey:

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

Based on record review and interview, the facility failed to have a written record of any significant changes, any illness, that resulted in medical attention and failed to monitor the quantity and the quality of the resident's diet for 1 out of 4 sampled residents (Residents #1).

Findings Included:

On at 10:16 AM, the administrator stated "The day he went to the hospital, we observed a changed he wasn't his upbeat self in order. He had and . I sent him to the hospital." The administrator reported Resident #1 was sent to the hospital for a ; however there was no documentation or progress notes at the facility. The administrator stated she did not document anything because she has a standard license and she is not required to write progress notes because according to her, there was no significant change. The resident was acting unusually and that is why she sent him to the hospital.

A review of Resident #1's hospital records documented: The resident was admitted on , hospital admission documented: Patient is referred from ALF (Assisted Living Facility) for evaluation of general and not eating. Presenting complaint Emergency Medical Response states: that the patient is also does not want to eat since 3 days ago.

at 9:39 AM Resident #1's daughter stated, "I went to visit him at the home and he was having two cookies and a cup of coffee, and I complained to her about it. She was upset about the money and she text me through an email and she texted some of my dad's medical information. I felt that sharing his information via text was a violation of his privacy because she does not know me, she claimed that we were close. A couple of days after she gave me the invoice, she called me and told me that my dad had passed out and was taken to the hospital. When I went to the hospital, it seemed as he had lost . I spoke to him and he said he has been given food but he did not like any of the food and he had not been eating well."

A review of Resident #1's record showed the resident was admitted on . The health assessment dated showed medical history and diagnoses: ,

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SUMMARY STATEMENT OF DEFICIENCIES
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hyperplasia, . Physical or sensory limitations: Visual and Hearing loss, limited ambulation. or behavioral status: poor judgement as a result of memory loss. Nursing/treatment/ services requirements: none. Special precautions: precautions. Elopement risk: No. The resident needs assistance with ambulation, bathing, , and self-care (grooming), and transferring, also needs supervisions with eating and toileting. Special Diet instructions: No added salt. The resident needs assistance with self- administration of medications.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the facility failed to have an up-to-date admission and discharge log.

Findings included:

A review of the facility's admission and discharged log listed Resident #1 as admitted on and there was no documentation the resident was discharged to the hospital. Resident #2 was listed as admitted on and transferred to another location.

On at 9:15 AM observed Resident #2 was sitting in common room.

On at 10:01 AM the administrator stated Resident #1 was discharged on , because his doctor decided his needs where better met in a nursing home.

Class III

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