STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963790	**01/17/2019**
NAME OF PROVIDER OR SUPPLIER **GRAND VILLA OF DEERFIELD BEACH**	STREET ADDRESS, CITY, STATE, ZIP CODE **1050 SOUTHWEST 24TH AVENUE DEERFIELD BEACH, FL 33442**	

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

0000 - Initial Comments

Unannounced licensure complaint surveys, CCR #2018016493 and CCR #2018015568, were conducted on , and at Grand Villa of Deerfield Beach, License #8690. The facility had deficiencies at the time of the survey.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on record review and interview, it was determined the facility failed to ensure a resident met the criteria for admission ; in addition the facility failed to properly assess a resident to ensure that the facility could adequately and appropriate provide all physican order care needs for the resident, for 1 out of 3 sampled residents (Resident #2). As evidence of the facility failure to assess Resident #2 appropriatly prior to admission, resulting in the inappropriate admission of Resident #2.

The findings include:

Resident #2 was admitted to the facility on with the following diagnoses; Unspecified without behavioral disturbance; , unspecified and , unspecified. The health assessment (AHCA form 1823) dated revealed the resident suffered from generalized , used a walker for ambulation, got easily tired and needed supervision. , Resident #2 was oriented to person and place, was at times ; however, he was able to make some of his needs known. In addition, he needed medication administration.

Review of the facility's Pre-Determination Assessment form dated revealed that Resident # 2 used independently, he was able to follow directions, he expressed his needs and answered appropriately. The Plan of Care completed on confirmed the health assessment's indices and furthermore clarified that Resident # 2 needed moderate on assistance for all activities of daily living, prompting and cueing for meal selection and consumption. Although the AHCA form 1823 indicated that Resident #2 needed medications administration, the facility noted on their plan of care that Resident #2 required assistance with self-administration of medications. In section III (Special Precaution Instructions) of the Plan of Care, the facility noted that the resident used .

Review of the Hospice Interdisciplinary Plan of Care/Physician Orders (HIPC/POs) dated revealed Resident #2's prior state of distress was resolved. From 0-10 he received a score of 0 (distress). Another HIPC/POs dated also revealed that Resident #2 had no , zero on a

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scale of 0-10. Consequently, previously ordered 0.5 mg to be administered by twice daily for was discontinued on as per physician's orders.

Review of the Discharge summary dated revealed that Resident #2 was discharged because the resident was dependent. On at 11:12 AM during an interview with the Resident Care Coordinator (RCC), she reported that the facility accepts residents with . She motioned when asked that they have a standard license but they have nurses on duty.

During an interview with the Administrator on at 11:22 AM, she said that when the resident was admitted to the facility, they had no idea that the resident was dependent or had swallowing issues which they found out after their assessment. She said that they found these issues out the day of the admission. Furthermore, she added that in the Memory Care Unit, they don't accept residents with at all, because there is no way they can manage their . She said that they do not allow the facility staff to titrate (regulate) the . She continued and said that the reason why it took two months to discharge the resident, after they found out he could not manage his , was due to the family could not find another place and also because the resident was from time to time on crisis care with hospice.

A request to see the updated to physician's assessment which would support the facility's ground for discharging Resident #2 from the facility for lacking the ability to self-manage the and any other concerns could not be provided. The Administrator and the RCC both agreed that the facility did not have a new AHCA form 1823 for the resident. However, they reported that one was not done.

The facility failed to appropriately assess Resident #2's care needs with respect to the facility's admission policy and services the facility is able to provide/arrange for the resident. This failure resulted in Resident #2 being admitted to the facility inaccurately and delaying the arrangement of appropriate care services for the resident.

Class III

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

Based on observation and interview, the facility failed to ensure that all exits were maintained in a clean and safe manner.

The findings included:

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During the facility's tour on at 10:05 AM with the Resident Care Coordinator (RCC), many refuses were observed in the staircases of the facility. At the slope of the third floor staircase, there was a pile of debris in plastic bags place at the threshold of the descending stairs that posed a safety hazard. On the second Floor staircase, multiple empty carton boxes and trash were observed. And, right behind the second floor exit door, there were a seemingly broken table, an empty carton box and bags of debris (Photographic evidence retained).
The RCC indicated thereafter that she would have them removed.

Class III

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

Based on records review and interviews, the facility failed to maintain an accurate admission transfer and discharge log.

The findings included:

On at 9:37 AM during the Entrance Conference with the Resident Care Coordinator(RCC)/Director of Nursing or RCC, this writer made a request to review the facility's Admission/Transfer and Discharge log for all residents. At 11:44 AM, the RCC provided an electronic copy of the Admission transfer and discharge log that was incomplete. Based on confidential interviews conducted on , it was discovered that numerous admitted/discharge residents were not listed on the log. The log was noted to be inaccurate.

During an interview with the RCC, the Regional Operations Manager and the Business Office Manager on at 12:25 PM, they reported that there was a mistake in the record, there were omission of approximately 7 more names from the Admission/Transfer/Discharge log. An updated log was provided to the surveyor, at this time, for review. However, it was still noted the log was inaccurate and missing the names of admitted/discharged residents.

Class

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

Based on record review and interview, the facility failed to ensure that their Comprehensive Emergency Management Plan (CEMP) was up-to-date and approved by the county entity responsible for approval, as required.

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The findings include:

During an interview conducted with the Administrator on at 3:00 PM the facility's CEMP and approval letter were requested for review. The Administrator stated that she was not sure what the status of the CEMP was. She then emailed her Corporate office who sent her an email revealing that the last CEMP was approved until . The email further revealed that the facility had submitted the new plan on and that its approval was still pending.

During the exit interview with Administrator on at 3:10 PM , the findings were discussed; no further documentation was provided.

Class III