STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963757	**03/01/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIA VILLA	**5151 S.W. 61 AVENUE** **DAVIE, FL 33314**

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

0000 - Initial Comments

An unannounced licensure complaint survey, CCR #2018018454 was conducted on at Victoria Villa, License #8646. The facility had deficiencies at the time of the survey.

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

Based on observation, interview and record review, the facility failed to ensure that a resident met the criteria for continued residency and failed to have a resident reassessed after significant health changes, ; and the findings documented on a new Resident Health Assessment form (AHCA form 1823), for 3 out of 3 residents (Resident #1, Resident #2 and Resident #3).

The findings included:

Upon entrance into the facility at 7AM on , Resident #1 was observed sitting in a chair in the activity room with a board over the chair (creating a table top), the table was observed with two latches on the bottom of the board locking and securing the board. Resident #1 had a empty coffee cup and a magazine in front of her. Resident #1 was observed trying to get up but could not get up due to the wooden board locked and attached to the table.

On at 7:05 AM, the nurse was observed in the dining room monitoring about 10 residents. The nurse had to pass the activity room, to get to the dining room and the nurses station was also located inside of the activity room. The nurse stated when she came on duty at 7AM, the resident was already locked into the table. The nurse stated at this time, she did not attempt to unlatch the resident from the locked table or question why the resident was being restrained. Upon return to the activities room where the chair was located the resident had been unlatched from the chair.

An interview was attempted with Resident #1 on at 7:11 AM. However, the resident was unable to be interviewed due to status.

Record review revealed Resident #1 was admitted to the facility in . A review of the AHCA form 1823 revealed the resident requires assistance with all activities of daily living (ADL's) due to , a status of alert, and resistant to redirection and the resident was identified as an elopement risk. Further review of Resident #1's file revealed documentation on the progress notes that the resident was seen by the physician on due to aggressiveness towards staff and residents; the doctor adjusted the resident's medication(s). On , it was noted in the resident's chart that the resident continued to display aggressive behavior. The physician adjusted Resident #1's

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medication again on .

Observations on between 7:15 AM to 2:00 PM, revealed Resident #1 would continuously pace the entire facility. The resident was observed to be shaking the doors attempting to leave the facility but all doors to exit the facility was locked. Observations further revealed staff members constantly trying to redirect the resident with activities. However, the resident would still be exit seeking after about 3 minutes or become aggressive with staff members.

During mulitple confidential interviews conducted on , revealed the facility had the tables (2 in total) made for residents like Resident #1 who always wants to get up and walk around. It was further stated that Resident #1 is the main one who sits in the chair with the table, in which she is locked in to prevent staff from having to monitor her constant whereabouts in the facility. It was further stated that sometimes, Resident #1 would be at the chair/ table until she starts to bang on the table. Then, they will unlock the latches to allow Resident #1 to walk around the facility. It was also stated that sometimes Resident #1 can become aggressive during redirection and has caused injury to employees.

An interview was conducted on at 1:48 PM regarding Resident #1 being restrained. The Administrator was aware about the resident being restrained. The Administrator stated she does not know how to control the resident and the resident is always exit seeking and she is concern the resident might get hurt. She further stated lately, Resident #1 exit seeking has worsen. At this time, the Administrator agreed the facility failed have her reassessed due to a significant health decline and began to reconsider the resident appropriateness..

b) During the lunch hour between12:30 PM and 1:30 PM on /2019observations revealed total transfers for Resident #2. The resident was observed unable to ambulate from the chair, to transfer to the wheelchair. Staff A lifted Resident #2 up underneath his arms and attempted to walk. Resident #2 attempted to take a step and began stumbling. Staff B quickly brought a wheelchair over so that Resident #2 can be pushed in a wheel chair to the dining room. Two staff members were observed lifting him from each side of his clothes out of the wheelchair and holding his pants to get a grip of him. Staff members were observed lifting residents and positioning wheelchairs for residents to be seated in. At this time, the Residents did not demonstrate any type of willingness to assist during the transfer. Resident #2 was fully dependent on staff members to get him up out of the reclining chairs to the chairs into the lunchroom and from the lunchroom, chairs to the chairs in the activity room.

Record review revealed Resident #2 was admitted to the facility on . The AHCA form 1823 dated /018 revealed Resident #2 was diagnosed with , , , ,

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, and . Resident #3 status revealed he was orient to self, required assistance with all activities of daily living (ADL) except for ambulation, noted the resident is unable to ambulate.

Further record review revealed Resident #2 is not receiving any hospice services. Further record review revealed the resident physician noted the significant decline with the resident unable to walk and transfer on . Review of the resident progress notes revealed the nurse spoke with the family member on and informed that the Resident has been declining and unable to walk.

An interview was conducted with the Administrator on at 3:05 PM, it was stated that Resident #2 has been declining for about two weeks. The Administrator at this time agreed that she failed to have the resident reassess after a significant health change.

c) During observation between 10:30 PM and 2:30 PM on revealed total transfers for Resident #3. The resident was observed unable to ambulate from the chair, to transfer to the wheelchair. Staff A lift Resident #3 up underneath his arms and attempted to walk. Resident #3 attempted to take a step and began stumbling. Staff B quickly brought a wheelchair over so that Resident #3 can be pushed in a wheel chair to the dining room. Two staff members were observed lifting him from each side of his clothes out of the wheelchair and holding his pants to get a grip of him. Staff members were observed lifting the resident and positioning in the wheelchair to be seated in. At this time, Resident #3 did not demonstrate any type of willingness to assist during the transfer. Resident #3 was fully dependent on staff members to get him up and out of the reclining chairs to the chairs into the lunchroom and from the lunchroom chairs to the chairs in the activity room.

Record review revealed Resident #3 was admitted to the facility on . The AHCA 1823 form dated revealed Resident #3 was diagnosed with , , , and risk for . Resident #3 status revealed he was to time and place, required assistance with all activities of daily living (ADL) except for ambulation the resident required supervision.

Further record review revealed Resident #3 is not receiving any hospice services. A review of the resident's progress notes revealed the nurse spoke with the power of attorney (POA) on and informed that the Resident has been declining and unable to walk. It was further noted the POA stated they did not want any testing done at this time and instructed the nurse to continue to monitor Resident #3.

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An interview was conducted with the Administrator on at 3:03 PM, it was stated that Resident #3 has been declining and his family was informed. The Administrator stated the family member did not want him to have any major testing done at this time. The Administrator at this time, agreed that the resident is inappropriate due to his decline and fail to have the resident reassessed after a significant health change.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(l)

Based on observation and interview the facility failed to adhere to the elopement standards as required.

The findings included:

a) Observations on from 10:00 AM - 3:00 PM revealed Resident #1 was a exit seeker. The resident was observed to continuously tug on the door handles and shake the door bars seeking exit out of the facility. Staff members would attempt to redirect her, sometimes she comply with redirecting but many times the resident would show signs of aggressiveness towards the staff.

An interview was conducted on at 3:12 PM with the Administrator. The Administrator was informed Resident #1's health assessment form stated the resident is an elopement risk. The Administrator acknowledged this information. The Administrator was also informed that the Resident had no form of special identification on her persons related to the minimum elopement standards. The Administrator acknowledge that she is familiar with this requirement of the minimum elopement standards for residents identified in the facility as an elopement risk. She further confirmed that she had not complied with the requirements for Resident #1.

b) A request was made to review the facility elopement drills for - ; the Administator was unable to privide the documentation. The Administrator stated on at 1:01 PM that so many other things were going on, they did not conduct any elopement drills for the year.

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation, record review and interview the facility failed to provide a Physician order

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theraputic diet for 6 of 6 sampled residents during lunch observations.

The findings included:

Lunch observations on at 12:15 PM revealed all plates were made and served the same having cottage cheese, fresh fruit, the residents who require puree was served applesauce on top of the cottage cheese with a whole muffin on the plate as well. As residents were served the chef would take the fork and break up the muffin on top of the cottage cheese in big chunks for residents who required a pureed diet. The DON and HR supervisor assisted the chef in breaking up the muffin in big chunks and mixing it in the cottage cheese and apple sauce for the residents. Both the DON and HR Supervisor was present in the lunchroom while lunch was being served and was also observed breaking the muffin into chunks for the residents who required a puree diet.

Record review revealed a list of 6 residents who had physician orders for all meals to be have a pureed consistency. This list was posted inside of the kitchen where all meals are prepared and also in the Supervisors office.
An interview was conducted after all residents were served their lunch with the Director of Nursing (DON), the DON stated she felt as if the consistency of the meal being served was pureed. The surveyor explained a puree consistency is usually a creamy paste or the meal being smooth textured and/or liquefied. At this time, the DON agreed that the meal was very chunky in consistency and did not have a pureed, smooth or creamy paste consistency.

An interview conducted with the chef on at 1:45 PM, she stated the way she served the meal to the residents who require a puree diet is the way she was taught by the chef (who is currently on vacation). She stated she was aware that the consistency was wrong but that is the way they always do it there. She further stated the kitchen does have a food processor and that the residents who required a pureed diet that their food should have been blended in the processor for a smoother consistency. She further stated however, that is not what she has observed and that is not how she was trained at the facility from the chef who is currently on vacation.

An interview was conducted with the Administrator on at 1:48 PM and she confirmed the findings.

Class III