STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968466	**05/10/2017**
NAME OF PROVIDER OR SUPPLIER **GRAND VILLA OF DELRAY WEST**	STREET ADDRESS, CITY, STATE, ZIP CODE **5859 HERITAGE PKWY** **DELRAY BEACH, FL 33484**	

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

0000 - Initial Comments

An unannounced relicensure survey was conducted on through at Grand Villa of Delray West, License # 12362. The facility had deficiencies at the time of the visit.

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, interview and record review, it was determined the facility failed to provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. on the Memory Care Unit of the facility and the facility's failure to develop and maintain policies related to Reporting Allegations of , Neglect, and , .

The findings included:

1) During observational tour of the Memory Care Unit, conducted with the Memory Care Director and Staff G (LPN), on beginning at approximately 9:55 AM, they were asked where a telephone that is accessible for residents to make a private call is located on this unit. The Memory Care Director stated if a resident wanted to make or receive a private phone call that they would be taken into the Activities Staff Office. She was asked if this office remained unlocked so that the telephone could be accessible to residents at any time. She replied that it is locked in the evenings. She was asked how a phone is accessible to residents to make a private phone call in the evenings. She stated that if a resident wanted to make a phone call all they would have to do is ask a staff member to help them.

During subsequent interview and record review conducted with the ED (Executive Director), on beginning at approximately 12:25 PM, he had provided a copy of an email dated that indicated a single phone line is to be installed in the first living the Memory Care Unit with "a dial out number such as 9". The ED was asked why this phone line would have to have a dial out number for this Memory Care population, as it would make it even more difficult for them to place a phone call. He stated it is so they don't call 911. He also stated phone access for the Memory Care Residents to receive phone calls from family members has been a concern on that unit as the calls come to the main building and have to be transferred. A copy of an email, dated , indicated "we get several calls a day for residents". The ED confirmed that some residents in the Memory Care Unit have cell phones, but several do not have their own phone.

Review of the residency agreement/contract signed by residents or their representative, upon admission to the facility, reflects "Residents may use the designated telephone at any time to make local or toll-free calls. Residents should limit their calls to five minutes".

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0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on interview and record review it was determined the facility failed to ensure that each staff member, within 30 days after beginning employment or no earlier than 6 months before beginning employment, must submit a written statement from a health care provider documenting that the individual does not have any signs or symptoms of communicable for 2 of 4 sampled staff (Staff A and Staff C).

The findings included:

During interview and personnel record review conducted with the ED (Executive Director) and BOC (Business Office Coordinator), on beginning at approximately 10:45 AM, they were provided the opportunity to locate freedom from signs and symptoms of communicable documentation for the following staff within the required time parameters and were unable to do so:

1) Staff A with a date of hire noted as ; no documentation of freedom from signs and symptoms of communicable could be located; as verified by ED

2) Staff C with a date of hire noted as ; documentation of freedom from signs and symptoms of communicable was located and dated (8 months prior to hire); as verified by the BOC that this exceeded the 6 month time parameter prior to hire

Class III

0081 - Training - Staff In-Service - 58A-5.0191(2) FAC

Based on interview and record review it was determined the facility failed to ensure that each staff member received the required inservice trainings by a facility administrator or manager (or designee that is core certified) in accordance with Rule 59A-8.0095, F.A.C. for 2 of 3 sampled staff (Staff A and Staff B).

The findings included:

1) During interview and personnel record review conducted with the ED Executive Director; the EDT (Executive Director in Training); and the BOC (Business Office Coordinator), on beginning at approximately 10:45 AM, they were asked if the BOC was core certified as she was the instructor signing the training certificates for Staff A (date of hire noted as). The BOC confirmed that she had not passed the core competency test and needed to reschedule to take it. The ED stated he was not aware the individual's providing the mandatory trainings had to be core certified.

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2) During interview and personnel record review conducted with the ED, on beginning at approximately 12:00 PM, he was asked if the Human Resources Director was core certified as he was signed the training certificates for Staff B (date of hire noted as). The ED confirmed that the Human Resources Director is not core certified.

The required trainings include the following for staff who provide direct care to residents: 1 hour of training within 30 days of employment that covers the following subjects: reporting major incidents; reporting adverse incidents; facility emergency procedures including chain-of- command and staff roles related to emergency evacuation. Also 1 hour of trainings it to be provided by the facility in resident rights in assisted living facility; recognizing and reporting resident , neglect, and , . Also, 1 hour of training in safe food handling practices and 1 hours of training in the facility's elopement response policies and procedures.

Class III

0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC

Based on interview and record review it was determined the facility failed to maintain training certificates or copies of training certificates that included the trainer's credentials for 1 of 3 sampled staff (Staff C).

The findings included:

During interview and personnel record review conducted with the ED (Executive Director); EDT (Executive Director in Training) and the BOC (Business Office Coordinator), on beginning at approximately 12:00 PM, Staff C's training certificates were reviewed. She had all of the required training certificates on file, however, the credentials of the trainer/instructor were not noted on these certificates. The EDT signed the certificates. She produced a copy of her core certification documentation for review. However, she acknowledged that her credentials were not noted on any of the training certificates for Staff C (date of hire noted as as a Resident Care Associate).

Class

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

Based on observation and interview it was determined the facility failed to ensure that all mechanical equipment (fire sprinkler heads) are maintained in good working order for 1 of 5 resident observed (#).

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The findings included:

During medication observation conducted with Memory Care Staff A (LPN) in # , on at 8:30 AM, the fire suppression system sprinkler head located just outside of this resident's apartment noted to be heavily encrusted with popcorn ceiling overspray (photographic evidence obtained). Staff A stated she would have the Maintenance Director come to look at this.

During subsequent interview conducted with the Maintenance Director, on beginning at approximately 8:50 AM, he stated he had observed this fire sprinkler head with excessive popcorn ceiling overspray and that he did not consider this to be acceptable. He stated it would be corrected.

Class III

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

During record review and staff interview, the facility failed to properly report 3 incidents alleging possible resident , to the proper agency(ies), and failed to thoroughly investigate the allegations made, for 3 of 18 residents (Residents #17, #18, and #20)

The findings included:

During review of the grievance log on , documentation was found related to 2 incidents of possible , involving Resident #17 and Resident #18. These 2 incidents had no documentation attached to the grievance related to the reporting of the incidents to the necessary agencies, nor documentation of a thorough investigation being conducted of the allegations.

Indicent #1 - Family member for Resident #20 notified facility on that 2 blank checks had been stolen from his father's wanted the facility to know of the situation. Both checks were dated . The first check, in the amount of $450.00, was drafted on , and the 2nd check, in the amount of $1400.00, was drafted on . The checks were made out to 2 different individuals, but the handwritting was the same on both checks. The checks were cashed in Broward County. The Administrator encouraged the family member to file a police report. No other reports were filed by the facility.

Incident #2 - In / , 2017, Family of Resident #17 alleged that 2 items of jewelry were missing/stolen from their mother's apartment in the Memory Care Unit (necklace and bracelet). The family alleged, and provided appraisal certificates dated , that the appraised value of the 24 inch, 14 carat gold necklace, with 3 hexagon shaped pendants each holding a .23 round diamond, was

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estimated to be worth $2500; and the 14 carat gold Tennis Bracelet with 31 diamonds was allegedly appraised at $10,500.

In response to the Familiy's allegation, the Administrator alleged appraisals were not genuine and attached sample of an appraisal done by the same company, and recommended the family file a police report.

Incident #3 - On , Resident #18 alleged that his care associate (Staff F), who is employed by the faciilty and who the Resident claims he in love with, made personal calls from his apartment multiple times. Staff F told the resident that she had 2 children. The resident gave her $30 dollars, and Staff F told the resident it was "customary to give the kids money." The Resident claimed he did not give Staff F anything for Valentine's Day and she was "disturbed about it."
The Assistant Administrator spoke with Staff F, who denied the allegations. Staff F was taken off assignment to Resident #18 to prevent further contact.

On , Staff F was observed coming to Resident #18's the 2nd floor when she was assigned to the 3rd floor. Staff F claimed she was "looking for gloves."
No further investigation was conducted regarding these allegations.

Interview conducted with the Administrator on at 2:00 PM. He stated, "We recommended [the family of Resident #17] to file a police report. We were being provided with appraisals, but appraisals did not appear to be genuine. Family never responded so we did not do anything further."
The Administrator did not provide a reason as to why he did not initiate a police report on behalf of the resident in light of the missing jewelry.
The Administrator confirmed that no reports were filed with AHCA or the Department of Children and Families related to the allegation of missing/stolen jewelry submitted by the Family of Resident #17, or allegation of missing checks for Resident #20..

Regarding allegations filed by Resident #18, the Administrator stated, "No report was filed." The Adminstrator agreed that the allegations did fit into the definition of " ," but he claimed no report was filed with AHCA or the Department of Chidlren and Families because "this resident is very ...and later changed his story." A complete investigation was not conducted, as only Staff F, who was named in the allegation, was interviewed, and she denied the allegations. Even though Staff F was removed from Resident 18's care, she still had access to the resident, and was found on the same day Resident #18 filed the allegations trying to enter Resident 18's , claiming she was looking for gloves.

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When asked to see the protocol used for allegations regarding , Neglect and , the Administrator could not provide faciltiy policy and procedure for , Neglect and .

Class III