Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932401	A. BUILDING: _____ B. WING _____	R 01/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA RIO VISTA	1115 SE 6TH TERRACE FORT LAUDERDALE, FL 33316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments An unannounced revsit Licensure complaint survey, #2019013287, was conducted on at Villa RioVista. The facility had an uncorrected and a new deficiency identified at the time of the survey.	{A 000}		
A 010 SS=D	429.26(&9) FS; 59A-36.006(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (2) A physician, physician assistant, or nurse practitioner who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interest in the facility. (9) A , ill resident who no longer meets	A 010		

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A 010	Continued From page 1 the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met. 59A-36.006 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 59A-36.002, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care	A 010		

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A 010	Continued From page 2 provider, the resident must be discharged from the facility. (c) A , ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in rule 59A-36.021, F.A.C.	A 010		

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A 010	Continued From page 3 This Statute or Rule is not met as evidenced by: Based on a record review, observations, and interviews the facility failed to reassess and determine the continued appropriateness of residency for 2 out of 9 sampled residents. (Resident #4 and Resident #9) The findings include: a) On at approximately 10:00 AM, observation of Resident #9 with no identification wristband was made. Review of Resident #9's Health Assessment, AHCA Form (1823) dated revealed Resident #9 is an elopment risk and has periods of . (Photographic Evidence Obtained). At this time, the DON was questioned on why Resident #9 is not on the list of residents that are identified as at risk for elopment and wearing identification wristband. At this time, the DON stated that Resident #9 was when admitted to the facility and assessed as an elopment risk. The DON further revealed he believes Resident #9's state has improved and is no longer assessed as an elopment risk. On at approximately 10:15 AM, Resident #9's family Member as interviewed; confirming that Resident #9 state has not improved while residing at the facility and has early stages of and is still very . Further review of Resident #9's AHCA form 1828 revealed Resident #9 has been diagnosed with and ; does not require any nursing services, and is independent with all ADLs. On at approximately 10:15 AM. Resident #9 Family membered revealed Resident #9 does receive assistance with showers and	A 010		

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A 010	Continued From page 4 eating sometimes. Review of Resident#9 medical records revealed Home Health was order on . . . . . The facility failed to have the resident reassessed upon significant change and document the findings on a new AHCA 1823 form. The DON confirmed that Resident #9 needs to be reassessed for continued residency and a new AHCA 1823 form completed. b)On . . . . . at 9:00 AM, a list of residents assessed as at risk were provided by the DON to the surveyor . It was revealed that Resident #4 was identified as an elopment risk. A record Review was conducted on Resident #4 Health Assessment, AHCA Form (1823). (Photographic Evidence Obtained) It was revealed that Resident #4's 1823 documents that Resident #4 is not an elopment risk. At this time, the DON was interviewed and revealed that the facility forgot to have Resident #4's 1823 updated. On . . . . . at approximately 1:30 PM, an exit conference was conducted with the Administrator. The findings were discussed and acknowledged. Class III	A 010		
{A 032} SS=D	59A-36.007(8) FAC Resident Care - Elopement Standards 59A-36.007 (8) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or	{A 032}		

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{A 032}	Continued From page 5	{A 032}		

a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days.

1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.

2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative.

(b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for:

1. An immediate search of the facility and premises,

2. The identification of staff responsible for implementing each part of the elopement

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{A 032}	Continued From page 6 response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to sections 429.41(1)(a)3. and 429.41(1)(l), F.S. This Statute or Rule is not met as evidenced by: Based on interview, observations, and record review, it was determined the facility failed to make a minimum daily effort to determine that residents at risk for elopment have identification on their persons; and ensure elopment identification includes facility name and telephone number, for 7 out of 7 sampled residents identifed as an elopement risk. (Residents #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident # 8). The findings include: On at approximately 9:00 AM, the DON was interviewed and revealed that Residents #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident # 8. (Photographic Evidence Obtained) are elopement risk residents. It was further revealed they are wearing identification wristbands. On at approximately 9:20 AM and 12:00 PM observations of Residents #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident # 8, wristbands revealed	{A 032}		

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{A 032}	Continued From page 7 that the wristbands included the resident name and facility address. The facility failed to ensure the facility name and telephone number were on the or other form of identification. On at approximately 11:20, an interview was conducted with the Administrator, revealing identification wristbands will be ordered to include the facility name and telephone number. On at approximately 9:40 AM the DON was questioned on who is responsible for ensuring the residents are wearing their wristbands and how often does responsible person check. It was revealed the DON is responsible for ensuring residents identified as an elopment risk are wearing identification. It was further revealed the DON attempts to check persons every other day. Therefore, it was determined the facility failed to make a daily effort to ensure persons identified as an elopment risk have identification on them. On at approximately 1:30 PM an exit conference was conducted with the Administrator. The findings were discussed and acknowledged. Class III Uncorrected	{A 032}		