STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968957	01/13/2017
NAME OF PROVIDER OR SUPPLIER **GRAND VILLA OF DELAND**	STREET ADDRESS, CITY, STATE, ZIP CODE **350 E INTERNATIONAL SPEEDWAY BLVD** **DE LAND, FL 32724**	

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

0000 Initial Comments

A complaint investigation for CCR #2016013239 & CCR #2016012151 was conducted at Grand Villa of DeLand (License #12792) on . // . Grand Villa of DeLand had deficiencies found at the time of the investigation.

0025 Resident Care - Supervision

Based on observations, record reviews and staff interviews, the facility failed to notify resident's family or physician with a significant change in condition for 4 residents (Resident #1, #3, #4 and #5) out of 4 residents sampled.

The findings include:

1. A record review for Resident #1 revealed a physician order dated for a urinalysis to be collected. Upon further review of the record the sample was not collected as ordered, nor was the physician notified of the sample test not being conducted.

A progress note for Resident #1 dated reads " resident was feeling when she woke up this morning. She has been more than normal. We have been keeping her and got her soup for lunch. We called the family to keep them updated." There is no documentation that the physician was called with the resident change in condition.

A record review for Resident #1 revealed the family of the resident entered the facility on and called 911 to transport the resident to the hospital where she was admitted for a and .

An interview with the Memory Care Director on // at 2:15 PM confirmed the facility never called the physician to notify him of the resident's decline on or notified him of the facility not collecting a sample for a urinalysis as ordered.

2) A record review for Resident #2 revealed a physician's order dated to obtain a sample for testing. No documentation could be found in the residents record to verify the sample was obtained or documentation to notify the physician the sample was not obtained.

An interview with the Memory Care Director on // at 9:10 AM confirmed the facility did not collected the sample as of today's date for Resident #2 and the physician was not notified of the test not being done.

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3) Record Review was conducted for Resident #3 which revealed the resident had a 15-pound weight loss since , 2016.

Record Review was conducted for Resident #4 which revealed the resident had a 14-pound weight loss since 2016.

Record Review was conducted for Resident #5 which revealed the resident had a 24-pound weight loss from 2016 until .

There is no documentation the family or physician has been notified or interventions put in place to prevent the resident from further weight loss for Residents #3, #4, or #5.

An interview with the Memory Care Director on / at 2:55 PM confirmed the facility has no documentation that the family, caregivers, and physicians for residents #3, # 4, or #5 were contacted to notify them of the residents' weight loss,and the facility had no interventions in place to prevent any further weight loss.

A review of the facilities Policy and Procedure for Obtaining Resident Weights not dated reads " Residents are to be weighed upon admission and documented. Residents are to be weighed each month. The residents Physician should be notified of weight loss greater than 5 pounds. Should the physician change or write any new orders, an additional notation must be made in the residents condition log. Family/responsible party is notified accordingly and documented."

CLASS III

0055 Medication - Storage and Disposal

Based on observations and staff interviews, the facility failed to properly store medications in a secured cabinet or refrigerator, in a manner to that would prevent any of the 31 residents of the unit or visitors from accessing them without authorization.

The findings include:

During the initial tour of the memory care unit on / at 8:25 AM the door to the nurse's station was observed left open and no staff were seen in the nurse station.

An observation on / at 8:27 AM was conducted of Resident # 6 walking into the nurse's station

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and taking cups off the medication cart housed there.

An observation was conducted on I/ at 8:35 AM of an employee from a third party service obtaining for 2 residents from an unlocked refrigerator and items from an unlocked cabinet that is located in the nurses station and accessible to residents when unattended.

An interview with Employee B, Caregiver, on I/ at 8:45 AM confirmed the medications cabinet and refrigerator which house various creams, supplements and for the residents is not locked and are accessible to residents who would enter the station. She stated "We don't have a key to the cabinet so it stays unlocked."

Observation at 2:10 PM on I/ showed the door which secures the nursing unit was open, and no staff were present in the nurse's station. 5 residents were seen sitting in the lobby next to where the nursing station is located and there were no staff present to monitor the area or its contents, or to prevent unauthorized persons from entering or accessing the supplies in the nurse's station.

An interview with Employee E, Medication Technician, on I/ at 2:15 PM confirmed the door to the nurses station was open and not locked. She confirmed sometimes the door sticks and doesn't shut and is left open.

CLASS III

0081 Training - Staff In-Service

Based on record reviews and staff interviews, the facility failed to train staff for 1 hour in recognizing and reporting resident , neglect, and within 30 days of hire for 1 Employee (Employee F) out of 4 employee records sampled.

The findings include:

A record review for Employee F, Caregiver, revealed a hire date of I/ . A certificate was found for training recognizing and reporting elder , neglect, and but was not dated. (photographic evidence obtained)

An interview with the Business office Manager on I/ at 3:15 PM confirmed Employee F's

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certificate of training for recognizing and reporting elder , neglect, and was not dated and one could not verify the date the employee took the training based on the certificate in the file.

CLASS III

0089 /Other - Special Care

Based on employee record reviews and staff interviews, the facility failed to train staff for 4 hours within 3 months of hire on specific topics for 4 out of 4 employee records that were reviewed for training.

The findings include:

A record review for Employee F, Caregiver, revealed a hire date of . No documentation could be found in the employee record to verify the employee received 4 hours of -specific training within 3 months of hire.

A record review for Employee E, Caregiver, revealed a hire date of . No documentation could be found in the employee record to verify the employee received 4 hours of -specific training within 3 months of hire.

A record review for Employee B, Caregiver, revealed a hire date of . No documentation could be found in the employee record to verify the employee received 4 hours of -specific training within 3 months of hire.

An interview with the Business office Manager on at 3:15 PM confirmed Employee's B, E, and F did not have documentation in their employee record to verify the received 4 hours of training on specific topics within 3 months of hire.
At the time of the survey, this facility advertised as having Memory Care and had a section of the facility specifically dedicated to residents with Memory Care needs.
CLASS III

0152 Physical Plant - Safe Living Environ/Other

Based on observations, record review, and staff interviews, the facility failed to ensure all mechanical systems are in good working order for 1 out of 2 elevators used by the residents in the assisted living

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area of the facility.

The findings include:

An observation was conducted on the tour of the facility on I/ at 10:45 AM of an out of order sign on 1 out of 2 elevator's used in the facility.

An interview on I/ at 10:50 AM with Employee D, confirmed the elevators in the facility are not always operational or functioning properly. The employee confirmed the elevator in the facility has stopped working multiple times and staff as well as residents have been inside the elevator cart when it stopped working.

A review was conducted of a work order dated I/ that metal shaving were found in the hydraulic tank and recommended replacing.

An interview on I/ at 10: 54 with the Maintenance Supervisor, he confirmed the elevator has stopped working before and has to be "reset" . The supervisor confirmed staff members as well as staff members have been inside the elevator cart when it has stopped working. He stated "The elevators has a switch that needs to be reset and if I ' m not here the can go and do it so the residents and staff are not stuck on the elevator for a long time."

CLASS III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Grand Villa Of Deland
350 East International Speedway Blvd.
DeLand, FL 32724

RE: CCR #2016012151 and CCR #2016013239

Dear Administrator:

This letter reports the findings of a state licensure complaint survey that was conducted on , 2017 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than 27, 2017.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyors. Should you have any questions please call this office at -4201.

Sincerely,

Amanda Wisehart

Amanda Wisehart
Field Office Manager
Division of Health Quality Assurance

AF/AW/sm
Enclosure
XG90

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