

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932670	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER GRANDVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1706 OLIVE ROAD PENSACOLA, FL 32514		
(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 CCR #2012007129 was investigated at Grandview Assisted Living Facility. The complaint was partially substantiated. The facility had a deficiency at the time of survey.	A 000		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication administration, or other changes which resulted in the provision of additional services.	A 025		

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0990

E01U11

If continuation sheet 1 of 4

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932670	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER GRANDVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1706 OLIVE ROAD PENSACOLA, FL 32514		
(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 025	Continued From page 1 This Statute or Rule is not met as evidenced by: Based on staff interview and record review the facility failed to notify family of changes in condition for 1 (#1) of 4 sampled residents. The findings are: Interview with complainant on _____ at 1:30 PM indicated the resident was having increased _____ and the facility did not notify them. She stated she is the one who asked the facility to notify the physician. The facility did notify the physician and he assessed the resident and ordered a chest x-ray and ordered the following medications: _____ 40 milligrams daily and _____ 20 meq daily for fluid and _____ 1 puff daily to help breathing. He diagnosed resident #1 with _____ and _____ which are new for the resident. During this time the complainant says the facility did not call the family about any of the above. Review of the record for resident #1 indicated on _____ the nurse practitioner (NP) visited and staff reported to the NP resident #1 had increased use of their inhaler during the evenings. He assessed the resident and found _____ and ordered a chest x-ray and lab work to rule out _____. A chest x-ray was done _____ and _____ On _____ another chest x-ray was done. On _____ the nurse practitioner visited again and found the resident _____ and increased _____. The chest x-ray showed mild _____. The lung assessment revealed crackles. He ordered medications at this time to reduce fluids:	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932670	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER GRANDVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1706 OLIVE ROAD PENSACOLA, FL 32514		
(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 025	Continued From page 2 40 mg every day and 10 meq daily. Repeat Chest X-ray in one week. On the nurse practitioner visited again and staff reported resident #1 still has some episodes of increased with and has crackles and He ordered another chest X-ray and repeat in one week and continue medications. Interview with staff stated the family came in on and found the resident and told staff. The family called the facility on and was told the physician was going to visit today and she asked if they would call her back. The family went to visit on and the resident was more so than before and was told the physician had placed her on new meds. The family then spoke with the administrator about why the facility had not called her of the new meds. The administrator then showed her the chest x-ray with new diagnosis. Interview with staff indicated the resident went out to the on and afterwards the family took resident to the ER and she was admitted with Interview with nurse practitioner's office manager on at 3:30 PM stated they do not call families. The facility does that. We wouldn't known who to call in this case. We did not call the family during this time of the med changes and chest x-rays. Interview with administrator on at 1:00pm stated we don't call families concerning medical issues. We don't have nurses here to assess residents. The medical information is between the physician, family and resident. In this case we didn't call the family regarding resident's new diagnosis, new medications and chest	A 025		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11932670	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER GRANDVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 1706 OLIVE ROAD PENSACOLA, FL 32514		
(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 025	Continued From page 3 x-rays.	A 025		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Grandview
1706 Olive Road
Pensacola, FL 32514-7553

Dear Administrator:

Re: CCR #2012007129

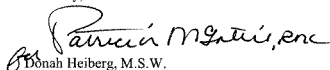
This letter reports the findings of a state licensure survey that was conducted on . 2012 by representative(s) of this office.

Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review after . 2012 to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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 surveyor. Should you have any questions please call me at 850-412-4540.

Sincerely,


Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone 850-412-4540; Fax (850) 922-9162