STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911052	08/02/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bernadette Aclf, Inc	520 Nw 2nd Avenue Hallandale, FL 33009	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= D
St - A - 0152 - 58a-5.023(3) Fac - Physical Plant - Safe Living Environ/other S-S= D

Specific Tag Findings:

0000-Initial Comments

An Assisted Living Facility Limited Nursing Services (LNS) monitoring survey was conducted on . Bernadette ACLF, had licensure deficiencies identified at time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on observation, interview and record review the facility failed to properly complete the Resident Health Assessment Form (AHCA Form 1823), for 3 of 3 sampled residents (Residents #1, #2 and #3).

The findings include:

a) Review of Resident #1's record, revealed the Resident Assessment Form was not properly completed on (date of the exam). Section 3, titled "Services offered by the facility" was blank. The Administrator's signature was noted with no date.

b) Review of Resident #2's record, revealed the Resident Assessment Form was not properly completed on (date of the exam). Section 3, titled "Services offered by the facility" was blank. Section 3 was also missing the Administrator's signature and date noted.

c) Review of Resident #3's record, revealed the Resident Assessment Form was not properly completed on (date of the exam). Section 3, titled "Services offered by the facility" was blank.

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On . . . . at approximately 1:00PM during an interview with the Administrator, she reviewed the records and confirmed she did not have a completed Assessment Forms on aforementioned residents.

Class III

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on record review and interview, it was determined the facility failed to ensure a Resident's Health Assessment form was 1) completed upon significant change and 2) reflective of a resident's current health status/care needs to ensure a resident met the criteria for continued residency, for 1 out of 3 sampled residents (Resident #1).

The findings include:

The following was noted specifically.

1) On . . . . at 11 AM, the resident was observed asleep sitting in her wheelchair in the living . . . . . The resident's lower legs were edematous and dressings were wrapped around both feet. Padded . . . . . were also noted.

2) Review of Resident #1's current health assessment dated . . . . . , noted a medical diagnosis of . . . . . , and . . . . . The health assessment noted the resident is unable to ambulate; wheelchair bound and requires assistance with all ADL's (activities of daily living).

During an interview with the Administrator at approximately 11:00 AM on . . . . . , it was reported that Resident #1 had a decline in health after her admission and developed . . . . . heel wounds. The wounds were assessed by the Podiatrist and are being treated daily by the Home Health Nurse. The Administrator stated the wounds are not improving. She reviewed the current Health Assessment form and agreed that it did not reflect the resident's current level of care needs and daily . . . . . care services that are being provided. It was also revealed the resident was not enrolled in Hospice Services. She revealed no further information was available for review.

3) Resident #1 was admitted to the facility on . . . . . with the following medical conditions; . . . . . and . . . . . The Resident Assessment form

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dated , revealed the resident is wheelchair bound and unable to ambulate. The resident requires total assistance with all ADL care and glucose monitoring twice daily. The resident has visual and requires regular cueing and assistance from staff to eat.

Further review of Resident #1's record revealed the resident developed heel on . The resident's primary physician was notified and evaluated the resident at his office on . Home Health Care was ordered to evaluate and began treatments on .

Review of the Home Health Communication Sheet dated revealed the resident has intact skin on both feet but the areas are very painful to touch. Review of the Home Health Certification and Plan of Care dated from to revealed the resident was treated for left chronic heel dark in color, measuring 3.5 x 2.0 x 3.2 cm with moderate drainage. The was cleansed with Normal and dressed with dry dressing.

On the Home Health Note revealed the nurse contacted the Physician to obtain care orders for on right heel, measuring 3 x 3 x 0.5 cm. The note documents the left heel is black but not open. Both heels are dressed and protective are applied.

Review of the Home Health Certification and Plan of Care dated , revealed the resident continues to have chronic of left and right heel requiring treatment. The wounds are black and drainage for left heel is small and clear in color. The right heel has no drainage.

On the resident is transported to the Podiatrist's office accompanied by a family member; X-rays are ordered of both feet and is ordered. Review of the resident's record failed to indicate documentation from the Podiatrist about the assessment of the wounds or the planned treatment. Review of the facility ' s Progress Notes also failed to indicate documentation of the condition of the wounds. The Progress Notes only documented that the care Nurse had completed daily treatment.

Review of Podiatrist orders dated revealed the following order; solution to all dry areas both heels and gauze dressing daily. The Administrator was unable to provide any physician progress notes or home health progress notes regarding the wounds.

Review of the facility Progress Note dated , revealed the resident is transported to X-ray, facility to take x-rays of both feet. The facility could not provide any evidence of the X-ray results. Review of the facility Progress Notes from thru , revealed the Home Health Nurse provided care. The facility was unable to provide documentation of the resident's

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Review of the Nursing Home Health record dated , revealed the treatment completed. The right heel is 1 x 1 cm and the left heel is 1 x 2 cm both is black. The note documents a goal to have the resident always turned in bed.

On at approximately 2:45 PM, an observation of the resident's heel wounds was conducted by Administrator (an LPN) in the presence of the Surveyor (licensed RN). The resident was in bed, her legs were drawn up in a position, padded were in place. The Administrator straightened the resident's legs and she released the gauze dressings on both the heels. The right and left foot had blackened golf ball size, 3-4 cm wounds on the back edge of the heel. The right heel had redness around the blackened edge and the resident expressed discomfort when this area was touched by the Administrator. The left heel had dried edges and no redness. The Administrator redressed the wounds and placed the protective on both feet. She stated, that the "resident draws her legs up when in bed and that has contributed to the development of the wounds". She stated, "the staff must assist the resident to turn when in bed".

On at approximately 3:00 PM during an interview with the Administrator, she stated that the resident has never walked and requires the assistance of 2 persons to transfer from bed to wheelchair. She stated the resident wears a diaper due to incontinence. She stated that the resident developed heel wounds even with the application of protective heel She stated that the Home Health Nurse has been communicating with the Podiatrist to obtain orders and discuss the wounds progress. The Administrator stated that she has not spoken with the Podiatrist and has never received any documentation about the wounds. During further interview with the Administrator, she was questioned if the facility had documentation of the wounds. She stated that she had not documented any observation of the wounds, including the size because the care Nurse was providing the treatments. It was revealed that she just noted that the Nurse came daily to provide the treatment in the resident's file.

During a further interview with the Administrator on at 3:15 PM, the following was revealed. She stated that the wounds were the size of golf balls on the back of both heels and black in color. She stated the wounds have not worsened but have not improved. The Administrator stated the resident had not been seen by the Podiatrist since , x-rays had been ordered. She stated that x-rays of both heels were taken on . She stated that appointments with the Podiatrist had been made by the family but were canceled numerous times. Therefore, the resident has never seen the Podiatrist. The Administrator stated, that a family member had spoken with the Podiatrist on

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but no appointment or transportation had been arranged. The Administrator stated, that she had left the responsibility of making the necessary medical appointments and transportation to the family but now realizes that she must take control and speak directly to the Podiatrist. She agreed that the facility should document the resident's medical condition and assist with access to medical care. The Administrator stated that she would call for an appointment to have the wounds evaluated.

Class III

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

Based on observations and interviews, the facility failed to provide a safe , sanitary living environment free from hazards.

The findings include:

During a tour of the facility with the Administrator on . . . . at 10:45 AM, the following was noted.

1. The resident next to the living grout around bathtub was blackened,and soiled. Privacy . . in shower was resting on window ledge, allowing vision to outside street. Administrator states that the residents do not use that . . . . She states that the blinds just . . . . down and the handy man will come to repair them.

2. The resident . . . . the kitchen, grout was missing around toilet bowl, the remaining grout was heavily soiled. Paint chipped in shower stall area, soiled walls and tub. Soiled shower chair. Blackened, soiled grout around tub edge, sections were missing creating holes.

3. Soiled cushions on chairs in dining . .

The Administrator was interviewed on . . . . at 11:00 AM and confirmed the findings.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Bernadette ACLF Inc.
520 Northwest 2nd Avenue
Hallandale, FL 33009

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on _ 2013 by a representative from 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. Staff from this office will conduct a review after **2013** 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 representative. Should you have any questions please call this office at (561) 381 - 5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager
Division of Health Quality Assurance

AMD/sf
Enclosure

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