STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911052	10/08/2013
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 - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= G
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G
St - A - 0164 - 58a-5.024(4) Fac - Records - Inspection Availability S-S= D

Specific Tag Findings:

0000-Initial Comments
An unannounced complaint survey, CCR# 2013009656 was conducted on . Bernadette ACLF, Inc. had licensure deficiencies found at the time of the visit.

Class II identified at A25

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on observation, interview and record review, the facility failed to provide care and services appropriate for the needs of a resident. As evidenced by the facility's failure to notify the physician of the development and worsening of multiple and on the resident's trunk, right elbow, right and left heel for 1 out of 3 sampled residents (Resident #1), which contributed to the resident becoming requiring a higher level of care. The resident was bedbound, required total care with all activities of daily living and was non-ambulatory. The resident had a medical history to include Dememtia, and Hyperlipedimia. The resident had visual , required cueing and assistance from staff to eat. The facility's failure to provide care and services directly threaten the physical, emotional health and safety of Resident #1.

The findings include:

A) Upon record review, during a prior Limited Nursing Services (LNS) monitoring survey conducted on , revealed Resident #1 was admitted to the facility on with medical conditions including , and . The Resident Health Assessment form (AHCA Form 1823) dated revealed the resident was wheelchair bound, and unable to ambulate. The resident required total assistance with all ADL (Activities of Daily Living) care and glucose monitoring twice daily. The resident had visual and required regular cueing and assistance from staff to eat.

During the LNS survey on , the following was noted:

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.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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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 .

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 the Administrator, a Licensed Practical Nurse (LPN) in the presence of the surveyor, a licensed Registered Nurse (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 and status because the care

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Bernadette ACLF, Inc	520 NW 2nd Avenue Hallandale, FL 33009	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

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 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.

At the time of the survey on the facility was found to lack documentation of the assessments and responses to treatment interventions that had been provided, lacked physician progress notes regarding the condition and failed to arrange for transportation to provide physician evaluation of the non-healing heel and the facility was cited for failure to ensure Resident #1 met continued residency criteria.

B) During this subsequent unannounced complaint visit, conducted on at approximately 12:00 PM, an entrance conference was held with the Owner/ Administrator. Her demeanor was very stiff and she raised her voice stating that she had "no comment about Resident #1, as requested by her attorney". The Owner stated that she would not answer any questions. She stated that there were no current medical records for the surveyor to review. She acknowledged that Resident #1 had visits by the Home Health Nurse for heel wounds. When asked by the surveyor, if any other wounds were present when a previous survey was conducted on , she would not answer the question or look at the surveyor. She stated that the resident developed distress on and she called 911 to transfer the resident to the ER (Emergency .

Review of the hospital records reveals the resident was admitted to the ER on at 9:05 AM. Review of the ER Nurses Notes reveals the resident was non-verbal, and opening eyes to sternal rubbing. She responded to pain by moaning. The resident was placed on at 3 liters via nasal cannula application. She had a large to the sacrum and wounds on heels. Pictures were taken of the wounds in the ER and [.....] was notified. The resident was and an central line for fluids was inserted along with a work was ordered, which showed lactic level at 3.9, indicating , normal range is 0.40-2.00. Other abnormal lab results were 31/ 1.1/WBC 17.6/ 2.02/ 5.4 and 17.3.

Review of the Emergency report on reveals the resident was admitted with decreased responsiveness. The resident has an sacral and a culture and sensitivity (C&S) specimen was taken from the site. Clinical Impression is documented as sacral , severe and . The plan of care included volume, .

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SUMMARY STATEMENT OF DEFICIENCIES
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debridement with pain control and plastic surgery consultation. The resident is placed on ... of ... and ...

Review of the ... Care ... Note dated ... revealed the following wounds:
1. Sacral ... measuring 16.5 x 20.0 x 6.0 cm 70% pink 30% soft tan/yellow with bone exposure, ... edges thickened.
2. Right ischium ... measuring 8.0 x 6.2 x 4.3 cm , 90% pink 20% yellow
3. Left ischium ... measuring 7.0 x 5.8 x 5.3 cm 70% pink, 30% yellow/tan
4. Left Hip ... measuring 3.0 x 2.5 x 0.7 cm 90% pink 10% yellow,
5. Right hip ... with unstageable ... measuring 3.5 x 1.5 with bridge of ... 100% covered with soft tan eschar.
6. Right elbow with purple/maroon discoloration over intact skin. Measuring 1.4 x 1.4 cm suspected deep tissue injury.
7. Right heel with unstageable ... 4.2 x 6.0 cm 100% eschar dry
8. Left heel with unstageable ... 3.8 x 6.0 cm 100% eschar, podiatrist to treat wounds.
All wounds were cleansed and a ... vac was applied to sacral ... Pictures taken.
Sacral ... C&S results from ... revealed organism ... moderate amount with mixed gram negative and positive flora in the ... The C&S results from ... included Bacteroides Uniformis as organism #2.

Review of the Critical Care MD (Medical Doctor) Progress note dated ... revealed the resident's vital signs were stable but the ... output was marginal despite multiple fluid boluses. The resident remains ... and nonverbal. A ... vacuum was placed in the sacral ... A nasal ... is inserted for nutrition. The Assessment/Plan was documented as large sacral ... status post debridement, ... with hemoglobin of 5.4 with no apparent ... and ... secondary to ... and ... and ... Plan to increase fluids, continue with ... care, ... prophylaxis, and transfer out of ... all plans discussed with resident's daughter.

Review of the Plastic Surgeon's Progress Note dated ... reveals the resident has a very extensive sacral ... with ... The resident will require ... to determine extent of ... Possible surgery for a diverting ... and ... Endoscopic ... (... feeding tube insertion.

Review of the Critical Care MD note dated ... revealed the residents' prognosis is poor. Lab work reveals the white ... count, ... remains high 15.2. On ... a chest x-ray showed development of ... with ... and patchy airspace and ... opacities. The resident has episodes of ... Medications are administered,a dietary consult and C- diff toxin screen were ordered.

Review of the General Surgeon notes from ... reveals the sacral wounds are very large and likely will never heal. The resident is awake and monitored daily for elevated bloodwork, she remains on ... and ... care is provided. The resident has poor ... function which delays the ... of the pelvis to determine the extent of the ... The Plastic Surgeon recommends surgical assessment if the ... cannot be completed. The notes document discussion with the residents daughter concerning the residents condition and medical options, ... insertion. On ... the ... of the pelvis is completed and shows large midline sacral ... with eroded cortex of the ... sacrum highly suspicious for a focus of ...

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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The Care Nurse and Plastic Surgeon visit the resident on . The sacral is debrided and additional cultures and are taken. The sacral measures 15 x 12 x 6.1 cm with undermining from 8 to 11 o'clock, 3.5 cm; 70 % red, 30% yellow with bone exposure. The left ischium measures 5.3 x 6.4 x 3.0 cm, undermining from 11 to 2 o ' clock , 4.2 cm, 80% red , 20% yellow. The right ischium measures 7.8 x 5.4 x 3.1 cm from 11 to 2 o'clock 5.1 cm 70% pink 30% yellow tissue. The vac is replaced into the sacral . Review of the Plastic Surgeons note dated reveals very extensive osteomyolytic sacrum to L4. Need orthopedic opinion regarding versus conservative management (care, and possible Hospice. Arrangements for Long Term Placement are considered for the resident.

Review of the Critical Care MD progress note dated , revealed the resident is clinically better with status improved. No with results pending. The resident is tolerating tube feedings via the discussion continues with daughter about insertion. The labs for and hemoglobin values are drifiting down without may require additional . The resident is transferred to the Telemetry unit and a hospice evaluation is ordered.

Review of the Code Blue Summary dated at 6:24 PM revealed the resident was found unresponsive in . A full code was attempted with and all efforts were terminated at 6:50 PM. The resident expired due to .

Review of the hospital Discharge Summary revealed the resident had discharge diagnoses including: sacral , acute failure, acidosis, of hips and heels, dyslipidemia, type 2 and .

On at 9:00 AM, a phone interview was conducted with the Manager of the Home Health Agency which had cared for the resident's heel wounds at the Assisted Living Facility, prior to the admission to the hospital. She stated that her agency only had physician orders for care for heel wounds. She stated that the orders were dated from 2013. She stated that she had no care orders for the sacrum or hips. She stated "this is the first that I' m hearing about them".

The Administrator/Owner failed to notify the physician of the development and worsening condition of the multiple for Resident #1. On admission to the hospital, the resident had multiple large, deep which were to the bone, directly threaten the well-being of Resident #1.

Class II

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

Based on observation, interview and record review, the facility failed to honor a resident's right by neglecting to obtain a higher level of care and notifying the physician with respect to the development and worsening of multiple and on the resident's trunk, right elbow, right and left heel, for 1 out of 3 sampled residents (Resident #1), which contributed to the resident becoming The resident was bedbound, required total care with all activities of daily living (ADLs) and was non-ambulatory. The resident had a medical history to include , Dememtia, and Hyperlipedimia. The resident had

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)

visiual , required cueing and asistance from staff to eat. The facility's failure to provide care and services directly threaten the physical, emotional health and safety of Resident #1.

The findings include:

A) Upon record review, during a prior Limited Nursing Services (LNS) monitoring survey conducted on revealed Resident #1 was admitted to the facility on with medical conditions including , and . The 1823 Resident Assessment form dated revealed the resident was wheelchair bound, and unable to ambulate. The resident required total assistance with all ADL (Activities of Daily Living) care and glucose monitoring twice daily. The resident had visual and required regular cueing and assistance from staff to eat.

During the LNS survey on , the following was noted:

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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	AL11911052	10/08/2013
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
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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 the Administrator, a Licensed Practical Nurse (LPN) in the presence of the surveyor, a licensed Registered Nurse (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 and status 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 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.

At the time of the survey on , the facility was found to lack documentation of the assessments and responses to treatment interventions that had been provided, lacked physician progress notes regarding the condition and failed to arrange for transportation to provide physician evaluation of the non-healing heel and the facility was cited for failure to ensure Resident #1 met continued residency criteria.

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	AL11911052	10/08/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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SUMMARY STATEMENT OF DEFICIENCIES
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B) During this subsequent unannounced complaint visit, conducted on ..... at approximately 12:00 PM, an entrance conference was held with the Owner/ Administrator. Her demeanor was very stiff and she raised her voice stating that she had "no comment about Resident #1, as requested by her attorney". The owner stated that she would not answer any questions. She stated that there were no current medical records for the surveyor to review. She acknowledged that Resident #1 had visits by the Home Health Nurse for heel wounds. When asked by the surveyor if any other wounds were present when a previous survey was conducted on , she would not answer the question or look at the surveyor. She stated that the resident developed distress on ..... and she called 911 to transfer the resident to the ER (Emergency .

Review of the hospital records reveals the resident was admitted to the ER on ..... at 9:05 AM. Review of the ER Nurses Notes reveals the resident was non-verbal, , and opening eyes to sternal rubbing. She responded to pain by moaning. The resident was placed on at 3 liters via nasal cannula application. She had a large to the sacrum and wounds on ..... heels. Pictures were taken of the wounds in the ER and [.....] was notified. The resident was and an central line for fluids was inserted along with a ..... work was ordered, which showed lactic ..... level at 3.9, indicating , normal range is 0.40-2.00. Other abnormal lab results were 31/ ..... 17.6/ ..... 2.02/ 5.4 and ..... 17.3.

Review of the Emergency report on reveals the resident was admitted with decreased responsiveness. The resident has an ..... sacral and a culture and sensitivity (C&S) specimen was taken from the ..... site. Clinical Impression is documented as ..... sacral , severe ..... and . The plan of care included volume, ... debridement with pain control and plastic surgery consultation. The resident is placed on ..... of ..... and .

Review of the ..... Care Note dated ..... revealed the following wounds:
1. Sacral ..... measuring 16.5 x 20.0 x 6.0 cm 70% pink 30% soft tan/yellow with bone exposure, ... edges thickened.
2. Right ischium ..... measuring 8.0 x 6.2 x 4.3 cm , 90% pink 20% yellow
3. Left ischium measuring 7.0 x 5.8 x 5.3 cm 70% pink, 30% yellow/tan
4. Left Hip ..... measuring 3.0 x 2.5 x 0.7 cm 90% pink 10% yellow,
5. Right hip ..... with unstageable ..... measuring 3.5 x 1.5 with bridge of 100% covered with soft tan eschar.
6. Right elbow with purple/maroon discoloration over intact skin. Measuring 1.4 x 1.4 cm suspected deep tissue injury.
7. Right heel with unstageable , 4.2 x 6.0 cm 100% eschar dry
8. Left heel with unstageable ..... 3.8 x 6.0 cm 100% eschar, podiatrist to treat wounds.
All wounds were cleansed and a vac was applied to sacral ..... Pictures taken.
Sacral ..... C&S results from revealed organism ..... moderate amount with mixed gram negative and positive flora in the . The C&S results from included Bacteroides Uniformis as organism #2.

Review of the Critical Care MD (Medical Doctor) Progress note dated revealed the resident's vital signs were stable but the output was marginal despite multiple fluid boluses. The resident remains and nonverbal. A ..... vacuum was placed in the sacral ..... A nasal is inserted for nutrition. The Assessment/Plan was documented as large sacral , status post debridement, with hemoglobin

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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SUMMARY STATEMENT OF DEFICIENCIES
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of 5.4 with no apparent [illegible] and secondary to [illegible] and [illegible] and [illegible]. Plan to increase fluids, continue with [illegible] care, [illegible] prophylaxis, and transfer out of [illegible] all plans discussed with resident's daughter.

Review of the Plastic Surgeon's Progress Note dated [illegible] reveals the resident has a very extensive sacral [illegible] with [illegible]. The resident will require [illegible] to determine extent of [illegible]. Possible surgery for a diverting [illegible] and [illegible] Endoscopic [illegible] ([illegible] feeding tube insertion.

Review of the Critical Care MD note dated [illegible] revealed the residents' prognosis is poor. Lab work reveals the white [illegible] count, [illegible] remains high 15.2. On [illegible] a chest x-ray showed development of [illegible] [illegible] with [illegible] and patchy airspace and [illegible] opacities. The resident has episodes of [illegible]. Medications are administered,a dietary consult and C- diff toxin screen were ordered.

Review of the General Surgeon notes from [illegible] reveals the sacral wounds are very large and likely will never heal. The resident is awake and monitored daily for elevated bloodwork, she remains on [illegible] and [illegible] care is provided. The resident has poor [illegible] function which delays the [illegible] of the pelvis to determine the extent of the [illegible]. The Plastic Surgeon recommends surgical assessment if the [illegible] cannot be completed. The notes document discussion with the residents daughter concerning the residents condition and medical options, [illegible] insertion. On [illegible] the [illegible] of the pelvis is completed and shows large midline sacral [illegible] with eroded cortex of the [illegible] sacrum highly suspicious for a focus of [illegible].

The [illegible] Care Nurse and Plastic Surgeon visit the resident on [illegible]. The sacral [illegible] is debrided and additional [illegible] cultures and [illegible] are taken. The sacral [illegible] measures 15 x 12 x 6.1 cm with undermining from 8 to 11 o'clock, 3.5 cm; 70 % red, 30% yellow with bone exposure. The left ischium measures 5.3 x 6.4 x 3.0 cm, undermining from 11 to 2 o ' clock , 4.2 cm, 80% red , 20% yellow. The right ischium measures 7.8 x 5.4 x 3.1 cm [illegible] from 11 to 2 o'clock 5.1 cm 70% pink 30% yellow tissue. The [illegible] vac is replaced into the sacral [illegible]. Review of the Plastic Surgeons note dated [illegible] reveals very extensive osteomyolytic sacrum to L4. Need orthopedic opinion regarding [illegible] versus conservative management ([illegible] care, [illegible] and possible Hospice. Arrangements for Long Term Placement are considered for the resident.

Review of the Critical Care MD progress note dated [illegible] revealed the resident is clinically better with [illegible] status improved. No [illegible] with [illegible] results pending. The resident is tolerating tube feedings via the [illegible] discussion continues with daughter about [illegible] insertion. The labs for [illegible] and hemoglobin values are drifting down without [illegible] may require additional [illegible]. The resident is transferred to the Telemetry unit and a hospice evaluation is ordered.

Review of the Code Blue Summary dated [illegible] at 6:24 PM revealed the resident was found unresponsive in [illegible]. A full code was attempted with [illegible] and all efforts were terminated at 6:50 PM. The resident expired due to [illegible].

Review of the hospital Discharge Summary revealed the resident had discharge diagnoses including: [illegible] [illegible] sacral [illegible] acute [illegible] failure, [illegible] acidosis, [illegible] of [illegible] hips and heels, [illegible] dyslipidemia, [illegible] [illegible] type 2 and [illegible].

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Bernadette ACLF, Inc	520 NW 2nd Avenue Hallandale, FL 33009	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

On [redacted] at 9:00 AM a phone interview was conducted with the Manager of the Home Health Agency which had cared for the resident's [redacted] heel wounds at the Assisted Living Facility, prior to the admission to the hospital. She stated that her agency only had physician orders for [redacted] care for [redacted] heel wounds. She stated that the orders were dated from [redacted] 2013. She stated that she had no [redacted] care orders for the sacrum or hips. She stated "this is the first that I' m hearing about them".

The Administrator/Owner failed to notify the physician of the development and worsening condition of the multiple [redacted] for Resident #1. On admission to the hospital, the resident had multiple large, deep [redacted] which were [redacted] to the bone, directly threaten the well-being of Resident #1.

(Cross reference to A 025)

Class II

0164-Records - Inspection Availability 58A-5.024(4) FAC
Based on interview, the facility failed to allow access for inspection of medical records to complete a complaint visit for, 1 out of 3 sampled residents (Resident #1).

The findings include:

An unannounced complaint visit was made at the facility on [redacted] at approximately 12:00 PM. An entrance conference was held with the Owner/ Administrator. The nature of the complaint involved the provision of Quality of Care for Resident #1 and pertinent medical records were requested. The Administrator/Owner stated that she did not renew her license and she was closing the facility due to recent survey actions. Her demeanor was very stiff, she raised her voice and stated that she had " no comment about Resident #1, as per advice from her attorney " . The Owner stated that she would not answer any questions. She stated that there were no current medical records available to review for Resident #1. The Administrator/Owner acknowledged that Resident #1 had been receiving Home Health Nursing care for wounds on both heels. She stated that the Resident #1 had developed [redacted] distress on [redacted] and she called 911 to transfer the resident to the ER.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

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

Dear Administrator:

Re: CCR #2013009656

This letter reports the findings of a complaint 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 Mananger

AMD/dso
Enclosure: State form 5000-3547
XG90

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