STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967024	04/09/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
La Grande Belle	5898 Orchard Pond Road Tallahassee, FL 32303	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0000 - - Initial Comments
St - A - 0007 - 58a-5.0181(1) Fac - Admissions - Criteria S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0053 - 58a-5.0185(4) Fac - Medication - Administration S-S= D
St - A - 0054 - 58a-5.0185(5) Fac - Medication - Records S-S= D

0000-Initial Comments
On an unannounced complaint survey CCR 2014003030 and CCR 2014003032 was conducted at La Grande Belle Assisted Living Facility. Deficiencies were cited.

0007-Admissions - Criteria 58A-5.0181(1) FAC
Based on clinical record review, staff and family interview it was determined the facility inappropriately admitted a resident for which care and services could not be provided for 1 or 6 residents reviewed (#5). The resident was and required glucose monitoring three times daily and injections and the facility did not have a licensed nurse on staff to provide the medications.

The findings are:

A review of the clinical record for resident #5 revealed the resident had a diagnosis of in both eyes and type II. This resident was to receive glucose monitoring 3 times a day and 8 units of with each meal if (less than)>50% of meal completed. The resident was discharged from the facility so no observation could be made of the residents ability to self administer his medications.

A review of the medication observation record for resident #5 revealed starting in of 2013 for resident #5 sugars were being documented twice daily on most occasions. There were 6 days in of 2013, 1 day in of 2013, 9 days in of 2013, 4 days in of 2013, 2 days in of 2013, 1 day in of 2013, 1 day in of 2013, 3 days in of 2013, 0 days in of 2014, 4 days in 2014 ad 3 days in of 2013 up to the date of discharge on that the glucose results had not been documented. All others days since admission indication to glucose checks had been done.

Also documented on the medication observation record for resident #5 indicated by initials of the staff members that was given: 11 times in of 2013, 5 times in of 2013, 2 times in of 2013, 0 in of 2013, once in 2013, 5 times in 2013, 7 times 2013, 12 times 2013, 7 times in 2014, 4 times in 2014, in of 2014 the MOR (medication observation record) as so many different marks it is hard to determine when the resident got because each day has a /, and initial and and R which the resident aide stated means refused.

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A review of the residents Health Assessment dated documents that the resident requires medications to be administered.

An interview was conducted with the resident #5 family via phone on and the daughter stated the resident was not able to check his own glucose or give his own secondary to being . The daughter had been checking the residents glucose 3 times a day and administering his as ordered prior to be admitted to the assisted living facility.

On at at approximately 3:30 PM an interview was conducted with the resident aide A. When asked who did the residents glucose checks she stated the resident pricked his finger but they had to guide his hand holding the meter to the on his finger. The staff member stated they would read the meter for the resident. When she was asked who administered the she stated the resident did. When asked how the resident, who was , was able to draw up his own she stated they guided him and told him how much he had in the syringe and he injected himself.

On at approximately 2:30 PM an interview was conducted with resident aide B. When asked if she passed medications she stated "Yes". When asked if she did sugar checks for the residents she stated, "I know how to do them but I watch". When asked if she gave injections to any of the residents she stated, "I have given them to the residents before but not recently, one time about one or two years ago".

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on clinical record review and staff interview the facility failed to ensure adequate and appropriate health care to 1 of 6 residents reviewed (#5) and by not following physicians orders for glucose monitoring, injections and by not providing licensed staff to administer medications.

The findings are:

A review of the clinical record for resident #5 revealed the resident had a Diagnosis of in both eyes and type II. This resident was to receive glucose injections 3 times a day and 8 units of with each meal if (less than) >50% of meal completed. The resident was discharged from the facility so no observation could be made of the residents ability to self administer his medications.

A review of the clinical record revealed the glucose was monitored twice daily. The physicians orders from admission are to monitor the glucose three times daily. The physicians orders from admission are to administer after each meal if (less than) >50% of meal completed. The medication observation only indicates one time for and does not indicate the time or for which meal.

A review of the medication observations for resident #5 revealed starting in of 2013 for resident #5 sugars were being documented twice daily on most occasions. There were 6 days in of 2013,

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1 day in of 2013, 9 days in of 2013, 4 days in of 2013, 2 days in of 2013, 1 day in of 2013, 1 day in of 2013, 3 days in of 2013, 0 days in of 2014, 4 days in 2014 ad 3 days in of 2013 up to the date of discharge on that the glucose results had not been documented. All others days since admission indication to glucose checks had been done.

Also documented on the medication observation record for resident #5 indicated by initials of the staff members that was given: 11 times in of 2013, 5 times in of 2013, 2 times in of 2013, 0 in of 2013, once in 2013, 5 times in 2013, 7 times 2013, 12 times 2013, 7 times in 2014, 4 times in 2014, in of 2014 the MOR (medication observation record) as so many different marks it is hard to determine when the resident got because each day has a /, and initial and and R which the resident aide stated means refused.

A review of the residents Health Assessment dated documents that the resident requires medications to be administered.

An interview was conducted with the resident #5 family via phone on and the daughter stated the resident was not able to check his own glucose or give his own secondary to being . The daughter had been checking the residents glucose 3 times a day and administering his as ordered prior to his admission to the assisted living facility.

On at at approximately 3:30 PM an interview was conducted with the resident aide A. When asked who did the residents glucose checks she stated the resident pricked his finger but the had to guide his hand holding the meter to the on his finger. The staff member stated they would read the meter for the resident. When she was asked who administered the she stated the resident did. When asked how the resident, who was , was able to draw up his own she stated they guided him and told him how much he had in the syringe and he injected himself.

On at approximately 2:30 PM an interview was conducted with resident aide B. When asked if she passed medications she stated "Yes". When asked if she did sugar checks for the residents she stated, "I know how to do them, I watch". When asked if she gave injections to any of the residents she stated, "I have given them to the residents before but not recently, one time about one or two years ago".

Class III

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0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on observation resident interview, family interview staff interview the facility failed to properly assist with self administration of medication by assisting with the monitoring of glucose readings for 1 of 6 residents reviewed (#5) and preparing syringes for injections for 2 of 6 (#4, 5) residents reviewed for self administration of medications.

The findings are:

On at approximately 11:30 AM resident #4 was observed while receiving his medications. Resident #4 requires . He was observed checking his own glucose. When the resident aide told him how much he was to receive and handed him the needle and the the resident sat in his chair and stared at the instruments. He asked the aide if she was going to give him his shot, and the aide stated no you have to give it to yourself. The resident did not have his glasses with him and stated he could not see without his glasses. At that time resident #4 was asked by this surveyor if the staff fill the syringes with and he stated that they usually do. He stated he had not done his own injection for a couple of days. The resident stated he was not aware that the staff were not nurses and that they were not allowed to help him with his injection.

A review of the clinical record for resident #5 revealed the resident had a Diagnosis of in both eyes and type II. This resident was to receive glucose injections 3 times a day and 8 units of with each meal if >50% of meal completed. The resident was discharged from the facility so no observation could be made of the residents ability to self administer his medications.

A review of the medication observations for resident #5 revealed starting in of 2013 for resident #5 sugars were being documented twice daily on most occasions. There were 6 days in of 2013, 1 day in of 2013, 9 days in of 2013, 4 days in of 2013, 2 days in of 2013, 1 day in of 2013, 1 day in of 2013, 3 days in of 2013, 0 days in of 2014, 4 days in 2014 ad 3 days in of 2013 up to the date of discharge on that the glucose results had not been documented. All others days since admission indication to glucose checks had been done.

Also documented on the medication observation record for resident #5 indicated by initials of the staff members that was given: 11 times in of 2013, 5 times in of 2013, 2 times in of 2013, 0 in of 2013, once in 2013, 5 times in 2013, 7 times 2013, 12 times 2013, 7 times in 2014, 4 times in 2014, in of 2014 the MOR (medication observation record) as so many different marks it is hard to determine when the resident got because each day has a (/), and initial and R which the resident aide stated means refused.

A review of the residents Health Assessment dated documents that the resident requires medications to be administered. An interview was conducted with the resident #5 family via phone and the daughter stated the resident was not able to check his own glucose or give his own secondary to being . The daughter had been checking the residents glucose 3 times a day and administering his as ordered.

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On at at approximately 3:30 PM an interview was conducted with the resident aide A. When asked who did the residents glucose checks she stated the resident pricked his finger but I had to guide his hand holding the meter to the on his finger. The staff member stated they would read the meter for the resident. When she was asked who administered the she stated the resident did. When asked how the resident, who was , was able to draw up his own she stated they guided him and told him how much he had in the syringe and he injected himself.

On at approximately 2:30 PM an interview was conducted with resident aide B. When asked if she passed medications she stated "Yes". When asked if she did sugar checks for the residents she stated, "I know how to do them I watch". When asked if she gave injections to any of the residents she stated, "I have given them to the residents before but not recently, one time about one or two years ago".

Class III

0053-Medication - Administration 58A-5.0185(4) FAC
Based on clinical record review, family interview and staff interview the facility failed to administer medications by a staff member who is licensed to administer medications to 2 of 6 (#4, 5) residents review for medication administration.

The findings are:

On at approximately 11:30 AM resident #4 was observed while receiving his medications. Resident #4 requires . He was observed checking his own glucose. When the resident aide told him how much he was to receive and handed him the needle and the the resident sat in his chair and stared at the instruments. He asked the aide if she was going to give him his shot, and the aide stated no you have to give it to yourself. The resident did not have his glasses with him and stated he could not see without his glasses. At that time resident #4 was asked by this surveyor if the staff fill the syringes with and he stated that they usually do. He stated he had not done his own injection for a couple of days. The resident stated he was not aware that the staff were not nurses and that they were not allowed to help him with his injection.

A review of the clinical record for resident #5 revealed the resident had a Diagnosis of in both eyes and type II. This resident was to receive glucose injections 3 times a day and 8 units of with each meal if (less than) >50% of meal completed. The resident was discharged from the facility so no observation could be made of the residents ability to self administer his medications.

A review of the medication observations for resident #5 revealed starting in of 2013 for resident #5 sugars were being documented twice daily on most occasions. There were 6 days in of 2013, 1 day in of 2013, 9 days in of 2013, 4 days in of 2013, 2 days in of 2013, 1

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Also documented on the medication observation record for resident #5 indicated by initials of the staff members that was given: 11 times in of 2013, 5 times in of 2013, 2 times in of 2013, 0 in of 2013, once in 2013, 5 times in 2013, 7 times 2013, 12 times 2013, 7 times in 2014, 4 times in 2014, in of 2014 the MOR (medication observation record) as so many different marks it is hard to determine when the resident got because each day has a (/), and initial and and R which the resident aide stated means refused.

A review of the residents Health Assessment dated documents that the resident requires medications to be administered. An interview was conducted with the resident #5 family via phone and the daughter stated the resident was not able to check his own glucose or give his own secondary to being . The daughter had been checking the residents glucose 3 times a day and administering his as ordered.

On at at approximately 3:30 PM an interview was conducted with the resident aide A. When asked who did the residents glucose checks she stated the resident pricked his finger but the had to guide his hand holding the meter to the on his finger. The staff member stated they would read the meter for the resident. When she was asked who administered the she stated the resident did. When asked how the resident, who was , was able to draw up his own she stated they guided him and told him how much he had in the syringe and he injected himself.

On at approximately 2:30 PM an interview was conducted with resident aide B. When asked if she passed medications she stated "Yes". When asked if she did sugar checks for the residents she stated, "I know how to do them, I watch". When asked if she gave injections to any of the residents she stated, "I have given them to the residents before but not recently, one time about one or two years ago".

Class III

0054-Medication - Records 58A-5.0185(5) FAC
Based on clinical record review and staff interview the facility failed to maintain the medications records for 1 of 6 residents (#5) reviewed for medication administration by not following the physician orders for glucose monitoring and injections.

The findings are:

A review of the clinical record for resident #5 revealed the resident had a Diagnosis of in both eyes

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and type II. This resident was to receive glucose monitoring 3 times a day and 8 units of with each meal if (less than) >50% of meal completed. The resident was discharged from the facility so no observation could be made of the residents ability to self administer his medications.

A review of the medication observations for resident #5 revealed starting in of 2013 for resident #5 sugars were being documented twice daily on most occasions. There were 6 days in of 2013, 1 day in of 2013, 9 days in of 2013, 4 days in of 2013, 2 days in of 2013, 1 day in of 2013, 1 day in of 2013, 3 days in of 2013, 0 days in of 2014, 4 days in 2014 ad 3 days in of 2013 up to the date of discharge on that the glucose results had not been documented. All others days since admission indication to glucose checks had been done.

Also documented on the medication observation record for resident #5 indicated by initials of the staff members that was given: 11 times in of 2013, 5 times in of 2013, 2 times in of 2013, 0 in of 2013, once in 2013, 5 times in 2013, 7 times 2013, 12 times 2013, 7 times in 2014, 4 times in 2014, in of 2014 the MOR (medication observation record) as so many different marks it is hard to determine when the resident got because each day has a (/), and initial and R which the resident aide stated means refused.

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An interview was conducted with the resident #5 family via phone on and the daughter stated the resident was not able to check his own glucose or give his own secondary to being . The daughter had been checking the residents glucose 3 times a day and administering his as ordered.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
La Grande Belle
5898 Orchard Pond Road
Tallahassee, FL 32303

Dear Administrator:

Re: CCR #2014003032, 2014003030

This letter reports the findings of a state licensure survey that was conducted on , 2014 by a 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. Staff from this office will conduct a review after , 2014 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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

for Patricia McGillicuddy
Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure
XG90

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