STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967024	04/23/2015
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

On , , 2015, an unannounced biennial survey including Limited Mental Health and Limited Nursing Services was conducted at La Grande Belle Assisted Living Facility. At the time of the survey, deficiencies were cited.

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

Based on observation, resident interview, staff interview and review of facility records the facility failed to demonstrate an appropriate grievance process and failed to address grievances for 1 of 3 residents interviewed (#2).

The findings are:

On at 12:03pm resident #2 was observed to be in his , lying in bed. He was observed lying on his right side and displayed facial grimacing at the time of the observation. Resident was on a size bed with a mattress observed to be about 3 to 4 inches thick except for in the center part of the mattress where the mattress was only about 2 to 3 inches thick.

Resident #2 stated that he was not going to go eat with the other residents because he was waiting for his pain medication to take effect. He stated that he had several "slipped disks" in his back and that the mattress he had to sleep on caused him to have frequent pain in his back. The resident stated that he had told the staff about the mattress and all they had been able to tell him was that he would have to discuss his problem with the facility owner. He stated that he had not been able to speak to the owner because the facility phone did not allow long distance calls and the owner lived in Miami.

At 2:50pm on an interview was conducted with staff member "D" who stated that she was aware that the resident had complained about his mattress and that this had been an ongoing complaint with resident #2. She stated that she was pretty sure that resident #2 had spoken to the owner concerning the mattress but stated that she was not aware of any plans to replace the mattress. During the interview, staff member "D" confirmed that there were restrictions placed on the facility phone and that they were not able to make any long distance calls on the phone. This was verified by demonstration when a call was placed from the facility phone to a long distance number that belonged to the owner of the facility. When dialed, the operator stated that the call could not be completed due to restrictions placed on the phone service and the service provider would have to be contacted for further information. The staff member stated that she did not have any documentation regarding the complaint voiced by resident #2 regarding his mattress.

Class III

0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC

Based on record review and staff interviews, the facility failed to conduct and elopement risk assessment for 6 of 6

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0032 Continued From page 1

residents (1, 2, 3, 4, 5 and 6) and failed to provide documentation of elopement drills conducted pursuant to Section 429.41(1)(a)3 and 429.41(1)(1), F.S.

The findings include:

Review of chart for Resident 1 revealed no elopement risk assessment and there was no photo identification for the resident.

Review of chart for Resident 2 revealed no elopement risk assessment and there was no photo identification for the resident.

Review of chart for Resident 3 revealed no elopement risk assessment and there was no photo identification for the resident.

Review of chart for Resident 4 revealed no elopement risk assessment and there was no photo identification for the resident.

Review of chart for Resident 5 revealed no elopement risk assessment and there was no photo identification for the resident.

Review of chart for Resident 6 revealed no elopement risk assessment and there was no photo identification for the resident.

On - at 12:35pm a telephone interview was conducted with the owner of the facility. He stated that all residents should have a photo identification in their charts. When advised that his staff was unable to locate or provide photographs of the residents he stated he will work to correct the deficiency.

On - at 1:00pm an interview was conducted with Staff C revealed she was unaware of any elopement drills being conducted and was not able to produce documentation of any elopement drills being conducted since last survey.

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and staff interview, the facility failed to ensure evidence of negative ( ) examinations were maintained on an annual basis for 3 of 3 staff reviewed (A, B and C) and failed to ensure staff members were free from communicable for 1 of 3 staff (C) reviewed.

The findings include:

Record review of the personnel file for Staff A revealed the last negative test on file was dated . There

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was no physician statement indicating Staff A was negative for since .

Record review of the personnel file for Staff B revealed the last negative test on file was dated . There was no physician statement indicating Staff B was negative for since .

Record review of the personnel file for Staff C revealed the last negative test on file was dated / . There was no physician statement indicating Staff C was negative for since / . There also was no documentation in the personnel record indicating Staff C was free from communicable .

On at approximately 12:50pm interview conducted with Staff C revealed she did not have an updated statement from her physician since / . At this time, she also confirmed there was no documentation in her personnel record indicating she was free from communicable .

Class III

0083 - Training - First Aid and - 58A-5.0191(4) FAC

Based on record review and staff interview, the facility failed to ensure current valid cards documenting completion of First Aid and ( ) for 2 of 3 sampled staff (A and B).

The findings include:

Record review of the personnel file for Staff A revealed First Aid and training for this staff member expired .

Record review of the personnel file for Staff B revealed First Aid and training for this staff member expired .

On at approximately 9:15am, interview conducted with Staff C revealed Staff A works the 7am - 3pm shift. Staff B works both the 11pm - 7am shift and the 3pm - 11pm shift. At this time she was unable to produce an updated First Aid and Training card for either staff member.

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record reviews and staff interview, the facility failed to ensure the availability of a resident Admission/Discharge/Transfer log and the availability of documented resident elopement response drills.

The findings include:

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On at approximately 9:00am, the surveyor requested a copy of the facility Admission/Transfer/Discharge log as well as all elopement policies, procedures and elopement response drill documentation from Staff C upon entering the facility for biennial survey.

On at approximately 1:00pm Staff C advised she was unable to find both the Admission/Transfer/Discharge log or the elopement response drill documentation. At this time she also advised she had not participated in any resident elopement response drills.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and staff interview, the facility failed to maintain documented evidence of Level II Background Screening results for 1 of 3 Staff (C) and failed to maintain documentation of resident elopement response drills for the facility.

The findings include:

1. Record review of the personnel record for Staff C revealed no documentation or evidence of a completed Level II Background Screening.

On at approximately 1:00pm, an interview conducted with Staff C confirmed her Level II Background Screening had been done; however, the documentation of the Level II background screening was missing from her personnel folder.

On at approximately 2:00pm a phone call to the Field Office Supervisor confirmed that Staff C had a completed Level II Background Screening in the database with an eligibility date of

2. On at approximately 9:30am Staff C was asked to produce elopement drill documentation. On at approximately 1:00pm a follow up interview with Staff C revealed she was unaware of any documentation for resident elopement response drills and was unable to find documentation that elopement drills were being conducted. At this time, stated she had not participated in elopement drills at the facility.

Class III

0162 - Records - Resident - 58A-5.024(3) FAC

Based on record review and staff interview, the facility failed to maintain weight records for 6 of 6 residents reviewed for weight documentation (1, 2, 3, 4, 5 and 6).

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The findings include:

Record review of resident records for Residents 1, 2, 3, 4, 5 and 6 revealed no documentation of weights for any of the residents.

On at approximately 9:31am, an interview conducted with Staff C revealed Staff B was responsible for recording weights for residents. She stated that Staff B currently has no working phone and is not scheduled to come to work today; therefore, she was unable to locate or provide any weights for any of the residents in the facility.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and staff interviews, the facility failed to properly report an adverse incident involving an event in which law enforcement was contacted.

The findings include:

Record review of the chart for Resident #4 revealed an unsigned, handwritten document dated which read, "To whomever it may concern, I (Staff D) witness (a former female staff member) being by (Resident #4). We were in the living (Resident #4) came out his charged at (former female staff member) and started beating her. I tried to stop (him) and he started at me but I was not hit."

On at approximately 10:25am, interview with Staff D revealed this was her statement regarding the incident. She stated the resident had been refusing his medications and when he does this, his behaviors become aggressive. She stated the former staff member was and hit in the head but she said she was okay. She stated Resident #4 came out of his approached her sitting in the chair and started hitting her. When asked what happened after the , she stated she called law enforcement who came to the facility and they took the resident to a local crisis stabilization unit. She stated she called the owner and reported the incident to him and he told me to write down what happened and put it in the resident's chart.

On at approximately 12:35pm, a telephone interview was conducted with the owner who stated he did not believe the incident met the criteria for reporting. He confirmed law enforcement was contacted and the resident was sent to the hospital for stabilization.

Class III

L241 - LMH - Records - 58A-5.029(2) FAC

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Based on record reviews and staff interview, the facility failed to ensure the availability of a resident Admission/Discharge/Transfer log identifying which residents were Limited Mental Health. The facility failed to ensure staff had updated Limited Mental Health training for 3 of 3 staff reviewed. The facility failed to ensure there was a , Agreement with the local community mental health provider.

The findings include:

On at approximately 9:00am, the surveyor requested a copy of the facility Admission/Transfer/Discharge log from Staff C upon entering the facility for biennial survey.

On at approximately 1:00pm Staff C advised she was unable to find the Admission/Transfer/Discharge log. When asked how the facility was able to identify which residents were Limited Mental Health residents, she stated she was unsure. When asked if any residents were receiving mental health services through the local community mental health center she stated she was not aware of any residents who were receiving mental health services.

Record review of personnel records for Staff A, B and C revealed no documentation of Limited Mental Health training.

Record review of chart for Resident 1 revealed a diagnosis of .

Record review of chart for Resident 3 revealed a diagnosis of .

Record review of chart for Resident 4 revealed a diagnosis of .

Record review of charts for Residents 1, 2, 3, 4, 5 and 6 revealed no evidence of a agreement with the local community mental health provider and no evidence of a Community Living Support Plan for any of the residents.

On at approximately 12:35pm a telephone interview was conducted with the Owner who revealed he was not aware that staff had no documentation of received Limited Mental Health training.

Class III

L242 - LMH - Responsibilities of Facility - 429.075(2) FS; 58A-5.029(3) FAC

Based on record reviews and staff interview, the facility failed to ensure there was a Agreement with the local community mental health provider for 1 of 1 sampled resident with documentation indicating the resident was Limited Mental Health (Resident #4). The facility failed to determine if Resident #1 and #3 were Limited Mental Health residents requiring a Community Living Support Plan for 2 of 3 sampled residents with a mental health

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diagnosis.

The findings include:

On , at approximately 9:00am, the surveyor requested a copy of the facility Admission/Transfer/Discharge log from Staff C upon entering the facility for biennial survey.

On , at approximately 1:00pm, Staff C advised she was unable to find the Admission/Transfer/Discharge log. When asked how the facility was able to identify which residents were Limited Mental Health residents, she stated she was unsure. When asked if any residents were receiving mental health services through the local community mental health center she stated she was not aware of any residents who were receiving mental health services.

Record review of chart for Resident 1 revealed a diagnosis of [redacted]. There was no documentation of a Community Living Support Plan.

Record review of chart for Resident 3 revealed a diagnosis of , There was no documentation of a Community Living Support Plan.

Record review of Resident 4 records revealed a diagnosis of and an old Community Living Support Plan from the previous Assisted Living Facility where the resident resided in 2013. There was no evidence of an updated Community Living Support Plan.

The facility was unable to determine whether the other residents who had a mental health diagnosis were designated as Limited Mental Health residents receiving services.

On , at approximately 12:35pm a telephone interview was conducted with the Owner which revealed he was not aware that the resident records had no documentation of Community Living Support Plans.

Class III

L243 - LMH - Training - 429.075(1) FS; 58A-5.0191(8) FAC

Based on record reviews and staff interview, the facility failed to ensure staff had updated Limited Mental Health training for 3 of 3 staff reviewed and the facility failed to ensure there was a Agreement with the local community mental health provider for 3 of 3 residents with a mental health diagnosis (1, 3, and 4).

The findings include:

On , at approximately 9:00am, the surveyor requested a copy of the facility Admission/Transfer/Discharge log from Staff C upon entering the facility for biennial survey.

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On at approximately 1:00pm, Staff C advised she was unable to find both the Admission/Transfer/Discharge log. When asked how the facility was able to identify which residents were Limited Mental Health residents, she stated she was unsure. When asked if any residents were receiving mental health services through the local community mental health center she stated she was not aware of any residents who were receiving mental health services.

Record review of chart for Resident 1 revealed a diagnosis of . There was no documentation of a Community Living Support Plan.

Record review of chart for Resident 3 revealed a diagnosis of . There was no documentation of a Community Living Support Plan.

Record review of Resident 4 records revealed a diagnosis of and an old Community Living Support Plan from the previous Assisted Living Facility where the resident resided in 2013. There was no evidence of an updated Community Living Support Plan.

Record review of personnel records for Staff A, B and C revealed no documentation of Limited Mental Health training.

Record review of the personnel record for the Owner of the facility revealed the last Limited Mental Health Training on file was 2009.

On at approximately 12:35pm, a telephone interview was conducted with the Owner which revealed he was not aware that all staff had no documentation of received Limited Mental Health training and that there was no evidence of update training in his own personnel record.

Class III

N278 - LNS - Records - 58A-5.031(3) FAC

Based on observation, staff interview, resident interview, and review of the resident's medical record, the facility failed to maintain documentation regarding the limited nursing services received by 1 of 1 (#5) resident receiving limited nursing services.

The findings are:

On at 9:52am, resident #5 was observed in his , sitting up in a wheelchair at the foot of his bed with a walker positioned in front of him. The resident had the lower portion of both of his legs wrapped in a tan colored bandage from the ankle extending to right up under each knee.

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An interview with resident #5 was conducted at 9:52am. Resident #5 stated that he was receiving nursing services from a home health company twice weekly because of multiple wounds he had on both of his legs, and that he was also working with a physical from the same home health company. The resident stated that he was able to change the wraps on his legs independently, and that he was able to perform the maintenance that the nurses had taught him.

Review of the resident's record showed that he had been admitted to the services of the home health company on / and was receiving care twice weekly related to chronic wounds with an acute case of requiring treatment. There were no nursing progress notes or monthly assessments observed in the resident's record.

On at 10:22am, an interview was conducted with staff member "C" who stated that she had provided me with all of the documentation and records they had for resident #5. She stated that the nurse would come out twice weekly to see resident #5, but stated that the nurse never communicated with the staff about the care provided to the resident and did not leave any documentation with the facility.

Class III

5-4-15

91 7108 2133 3937 4452 9573

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

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

Dear Administrator:

This letter reports the findings of a state licensure survey which included review of both Limited Nursing Services and Limited Mental Health services conducted on , 2015 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. Staff from this office will conduct a review after 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,

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

DH/kb
Enclosure
XG90

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

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
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