| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964582 | 07/10/2015 |
| NAME OF PROVIDER OR SUPPLIER<br>**CREEKSIDE SENIOR VILLAGE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9015 UNIVERSITY PARKWAY**<br>**PENSACOLA, FL 32514** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

**0000 Initial Comments**

An unannounced state licensure complaint survey was conducted on related to allegations contained in CCR 2015007048. Creekside Senior Living Assisted Living Facility had deficiencies at the time of the visit.

**0007 Admissions - Criteria**

Based on interview, record and policy review, it was determined that the facility failed to follow their own policies and state licensure requirements by accepting 2 of the 3 residents in the sample for admission who did not meet admission criteria related to existing (resident #1) and an existing unstageable (resident #2).

The findings are:

Resident #1

A record review as conducted for sample resident #1. The resident health assessment (AHCA Form 1823) was signed by an Advanced Registered Nurse Practitioner (ARNP) and dated A review of the facility "Move-In Information" page of the Residency Agreement indicates the resident was admitted to the facility on (the day after the resident health assessment was performed). Continued review of the resident health assessment revealed (under the section for "Special Precautions") sacral - 1.0 X 1.0 X 2.0 (centimeters)" and "Right heel 0.2 X 0.2 non-stageable 100% eschar". (Eschar is an area of tissue on the skin. It may appear as a black scab may with a thick collection of dry tissue.) Section 1 of the resident health assessment, paragraph C.3. poses the question "Any 3, or 4 pressure sores?". The adjacent column indicates "Yes", followed by a description of the sacral - 1.0 X 1.0 X 2.0 (centimeters)" and "Right heel 0.2 X 0.2 non-stageable 100% eschar".

Review of the ALF Physician's Order Sheet for sample resident #1, dated revealed order 12 "Cleanse sacral with normal apply opticell and cover with optifoam gently to sacrum daily and as needed".

The Resident Service Sheet for resident #1 was reviewed. The form was dated and initialed by the facility Memory Care Unit Manager. Hand written on the bottom of the form are the words "Amedisys HHC (Home Health Care) for (physical OT (occupational Nursing for care to sacrum and heel, air mattress for bed".

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964582 | 07/10/2015 |
| NAME OF PROVIDER OR SUPPLIER<br>**CREEKSIDE SENIOR VILLAGE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9015 UNIVERSITY PARKWAY**<br>**PENSACOLA, FL 32514** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

An interview was conducted with the facility Executive Director (ED) on at approximately 1:00 pm. She stated the resident (#1) was given a 45 day discharge notice, dated A copy of the discharge notice was provided. The discharge notice stated the discharge was necessary due to a "higher medical need". She also stated that as of this date, the family has been unable to find placement for the resident.

A review of ARNP notes dated reveal the resident has a to the sacrum, and an unstageable to the right heel, with the note "continue local WC care) HHC at discharge.

The record contained a Home Health Care order sheet dated and signed by a physician. Review of this form revealed that resident #1 has a sacral and care measurements of 0.7 X 0.5 X 2 cm depth. care instructions were included in the order, and their is a hand written note in the margin "faxed to (name of home health agency)

A review of the facility "Resident Notes" revealed an entry made at 1:50 pm on (date of admission). This resident note mentions that the (AHCA Form) "per 1823 on sacrum". A separate "Admission Note" form was found in the record, dated and under "completed description of patient condition" appears the hand written note on sacrum, right heel

The Home Health Agency visit treatment flow sheet was reviewed. Resident #1 received skilled nursing visits from the Home Health Agency for the purpose of care a total of 27 times during the period through

Resident #2

A record review was conducted for sample resident #2. The AHCA Form 1823 Resident Health Assessment dated and signed by the physician does not indicate any The facility Resident Admission Notes dated under "completed description of patient's condition" is handwritten to and "eschar to left heel 2.5 X 2.0 (cm). A separate skin assessment/status for dated the same date also reveals "type of problem - eschar", indicates the on the and the left heel eschar area with the same measurements. A handwritten note in the margin of the form "followed by (name of home health agency) for SN (skilled nursing care. The home visit treatment flow sheet was reviewed for the period through The home health agency provided care to this resident on 7 days during the period. Handwritten at the top margin of the form is left heel".

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964582 | 07/10/2015 |
| NAME OF PROVIDER OR SUPPLIER<br>**CREEKSIDE SENIOR VILLAGE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9015 UNIVERSITY PARKWAY**<br>**PENSACOLA, FL 32514** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

The facility Policy and Procedure for Move-in/Move-out Criteria was reviewed. Section I (Move-in Criteria), paragraph A.9. "Does not require skilled nursing care, as Florida State Law prohibits the Community from providing those services".

Article V - Term and Termination of the facility resident agreement for residents was reviewed. Paragraph B.1.(h), related to termination by the Community, states "Has health care needs that cannot be met in the Community, for reasons such as licensure, design or staffing, as determined by the Community".

Class III

**0010 Admissions - Continued Residency**

Based on interview, record and policy review, it was determined that the facility failed to follow their own policies and state licensure requirements by accepting 2 of the 3 residents in the sample for admission who did not meet admission criteria related to existing (resident #1) and an existing unstageable (resident #2).

The findings are:

Resident #1

A record review as conducted for sample resident #1. The resident health assessment (AHCA Form 1823) was signed by an Advanced Registered Nurse Practitioner (ARNP) and dated A review of the facility "Move-In Information" page of the Residency Agreement indicates the resident was admitted to the facility on (the day after the resident health assessment was performed). Continued review of the resident health assessment revealed (under the section for "Special Precautions") sacral - 1.0 X 1.0 X 2.0 (centimeters)" and "Right heel 0.2 X 0.2 non-stageable 100% eschar". (Eschar is an area of tissue on the skin. It may appear as a black scab may with a thick collection of dry tissue.) Section 1 of the resident health assessment, paragraph C.3. poses the question "Any 3, or 4 pressure sores?". The adjacent column indicates "Yes", followed by a description of the sacral - 1.0 X 1.0 X 2.0 (centimeters)" and "Right heel 0.2 X 0.2 non-stageable 100% eschar".

Review of the ALF Physician's Order Sheet for sample resident #1, dated revealed order 12 "Cleanse sacral with normal , apply opticell and cover with optifoam gently to sacrum daily and as needed".

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964582 | 07/10/2015 |
| NAME OF PROVIDER OR SUPPLIER<br>**CREEKSIDE SENIOR VILLAGE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9015 UNIVERSITY PARKWAY**<br>**PENSACOLA, FL 32514** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

The Resident Service Sheet for resident #1 was reviewed. The form was dated and initialed by the facility Memory Care Unit Manager. Hand written on the bottom of the form are the words "Amedisys HHC (Home Health Care) for (physical OT (occupational Nursing for care to sacrum and heel, air mattress for bed".

An interview was conducted with the facility Executive Director (ED) on at approximately 1:00 pm. She stated the resident (#1) was given a 45 day discharge notice, dated A copy of the discharge notice was provided. The discharge notice stated the discharge was necessary due to a "higher medical need". She also stated that as of this date, the family has been unable to find placement for the resident.

A review of ARNP notes dated reveal the resident has a to the sacrum, and an unstageable to the right heel, with the note "continue local WC care) HHC at discharge.

The record contained a Home Health Care order sheet dated and signed by a physician. Review of this form revealed that resident #1 has a sacral , and care measurements of 0.7 X 0.5 X 2 cm depth. care instructions were included in the order, and their is a hand written note in the margin "faxed to (name of home health agency)

A review of the facility "Resident Notes" revealed an entry made at 1:50 pm on (date of admission). This resident note mentions that the (AHCA Form) "per 1823 on sacrum". A separate "Admission Note" form was found in the record, dated and under "completed description of patient condition" appears the hand written note on sacrum, right heel

The Home Health Agency visit treatment flow sheet was reviewed. Resident #1 received skilled nursing visits from the Home Health Agency for the purpose of care a total of 27 times during the period through

Resident #2

A record review was conducted for sample resident #2. The AHCA Form 1823 Resident Health Assessment dated and signed by the physician does not indicate any The facility Resident Admission Notes dated , under "completed description of patient's condition" is handwritten to and "eschar to left heel 2.5 X 2.0 (cm). A separate skin assessment/status for dated the same date also reveals "type of problem - eschar", indicates the on the and the left heel eschar area with the same measurements. A

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11964582 | 07/10/2015 |
| NAME OF PROVIDER OR SUPPLIER<br>**CREEKSIDE SENIOR VILLAGE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**9015 UNIVERSITY PARKWAY**<br>**PENSACOLA, FL 32514** | |

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

handwritten note in the margin of the form "followed by (name of home health agency) for SN (skilled nursing care. The home visit treatment flow sheet was reviewed for the period through . The home health agency provided care to this resident on 7 days during the period. Handwritten at the top margin of the form is left heel".

The facility Policy and Procedure for Move-in/Move-out Criteria was reviewed. Section I (Move-in Criteria), paragraph A.9. "Does not require skilled nursing care, as Florida State Law prohibits the Community from providing those services".

Article V - Term and Termination of the facility resident agreement for residents was reviewed. Paragraph B.1.(h), related to termination by the Community, states "Has health care needs that cannot be met in the Community, for reasons such as licensure, design or staffing, as determined by the Community".

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Creekside Senior Village
9015 University Parkway
Pensacola, FL 32514

**RE: CCR #2015007048**

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2015 by a representative 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. **Please attach your corrective action and any additional documentation to support correction of identified deficiencies and send to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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,

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

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
SlideShare.net/AHCAFlorida