RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[illegible], 2016

Crestview Manor
603 North Pearl Street
Crestview, FL 32536
Becky Nash, Administrator

Dear [illegible]. Nash,

This letter reports the findings of a complaint survey (CCR# 2016007976) conducted by representatives of the Agency for Health Care Administration. **Your assisted living facility is directed to comply with the prescribed steps outlined below in order to correct the identified deficient practices.** Attached are the deficiencies cited during this inspection.

The investigation resulted in findings of noncompliance with the following areas:

A10 – Admissions – Continued Residency – Class II : The facility failed to communicate and coordinate care with a Hospice provider which led to missed baths and the development of a leg which required hospitalization.

A25 – Resident Care – Class II: The facility failed to provide proper care and services to meet the needs of the resident who was receiving hospice services and developed wounds requiring medical treatment.

Your facility must comply with the following:

1. The facility must develop and implement a policy and procedure for the coordination of care between third party providers and the facility. The policy must include who will be responsible for contacting and coordinating the third party providers, indicating how/when providers and the facility are notified of medical orders, specify notification instructions when the recommended care/ treatments are unable to be performed as ordered by the third party provider and how the facility will coordinate and provide oversight of the third party provider's care. The policy must address the facility's responsibility to document the coordination and oversight with the third party providers and the administrator's specific role in the coordination of care within the facility. As part of the policy, the provider visit notes must be maintained in the resident record. The facility must implement a written log for all residents receiving care from any third party providers. The log must include, at a minimum, name of resident who is receiving care, the name of the third party provider who is providing the care, and documentation of any care services and

treatments completed including the course of the progress of care/ services rendered to the resident. **This requirement must be met by , 2016.**

2. The facility must create a policy to address communication with health care providers and family members/ responsible parties following a change of condition. Examples include but not limited to: any condition which required medical attention, including changes in skin condition. The policy should include that the Administrator be notified immediately of any resident change and documentation be made in the medical record of all notifications and any orders or instructions given to the staff. The Administrator must have an active role in determining level of care options for the resident. All direct care staff must be trained on the new policy. Documentation of the training, content and sign-in sheet must be maintained in the facility and available for review by the Agency upon request. **This requirement must be met by , 2016.**

3. All residents recieving 3rd party services in the facility must be reassessed by a health care provider to determine if they are appropriate for continued residency in the facility. This face-to-face assessment by a health care provider must be documented on AHCA form 1823 and maintained in the residents' record. These assessments must be available in the facility for review by the Agency upon request. In addition, the responsibility for ensuring the facility can meet the needs of the residents rests with the administrator. The administrator is directed to review each resident's health assessment to ensure they meet residency criteria and their needs can be met at the facility. **This requirement must be met by , 2016.**

Please be advised that nothing in this Directed Plan of Correction limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please contact Donah Heiberg, Field Office Manager at (850) 412-4540 or Laura Manville, Assisted Living Enforcement Team Manager at 727-552-1955.

Sincerely,

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

DH/kb

D7JR

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910406	**08/04/2016**
NAME OF PROVIDER OR SUPPLIER **CRESTVIEW MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **603 NORTH PEARL STREET CRESTVIEW, FL 32536**	

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

0000 Initial Comments

An unannounced complaint survey for allegations contained within CCR#2016007976 was investigated at Crestview Manor Assisted Living Facility (license #5649) on . The allegations listed in the complaint were substantiated. At the time of the survey the facility had deficient practice.

0010 Admissions - Continued Residency

Based on family interview, staff interview and record review, the facility failed to coordinate care with a Hospice provider and ensure the appropriateness of continued residency for 1 of 4 sampled residents (#1). There was a lack of communication and coordination between the facility and the Hospice which led to missed baths and the development of a leg which required hospitalization.

The findings are:

1. Review of resident #1 Health Assessment dated indicated the resident had diagnosis which included and Post surgery Displaced foot with Skin . Resident #1 was alert and oriented but at times. The health assessment indicated Resident #1 needed assistance with ambulation and was independent with bathing and dressing, but contradicted this on page 5 where the assessment stated the resident needs assistance with showering and shampooing to be provided by self, staff and Hospice. Assistance with personal hygiene and self care provided by staff as needed.

Review of doctors' orders noted the resident was receiving Hospice services for diagnosis of and to left foot.

Review of the facility monthly assessments dated noted resident as of , needing staff assistance with bathing.

Review of Hospice Plan of Care noted an aide visits 3 times a week to provide baths. Review of the aides notes found the resident had been refusing baths. Further review of aide notes did not indicate the Hospice aide was communicating to ALF staff of refusing baths. Review of Hospice Skilled Nurse notes did not indicate the resident was refusing baths.

On at 1:20 pm, an interview was conducted with a family member of patient #1. The family member stated that patient #1 had old of her foot where she had to have skin . The family member indicated when patient #1 was admitted to the ALF she did not have an open to her foot. The ALF and Hospice did not tell me of the open area and her not wanting her baths. My

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mother said that Hospice and the facility did not bathe her and they didn't clean her on her foot or change the dressing.

Interview with Assisted Living Facility (ALF) Administrator on / at 8:30 AM indicated that Hospice staff did not tell us that the resident had been refusing showers for months. She said the resident never refused care by the facility. She said the Hospice staff never told them facility nor the family of the foot being bad. The policy for coordination with third party services was requested. The administrator stated that there is an agreement between the resident and the hospice, but not with the facility.

Interview with ALF staff E on at 12:30 PM indicated hospice aide and nurse will come in and may come to see staff saying they visited. Hospice staff do not relate all of the things they did. Did not know of the to resident #1's foot, did not know of refusal to showers.

Interview with ALF aide staff C and D on at 12:45 PM both indicated resident #1 is out to the hospital. We didn't help with baths, resident #1 had Hospice aides come in 2 times a week to bathe her. Resident #1 got up in wheelchair per self and would go out to smoke. She was independent and we helped with dressing some of the time.

Further record review lacked documentation of the ALF assisting with baths and knowing that the resident was refusing baths from Hospice aides.

Review of Hospice Plan of Care (PoC) for certification period - found patient #1 was admitted to hospice with a diagnosis of . Patient #1 lives in an Assisted Living Facility (ALF) and requires assistance with care. Goals by the skilled nurse indicate care will be established that meets the patient needs two times a week. The nurse will provide instructions/reinforcement related to skin care and complications.

Review of Hospice nurse visit notes found on 2+ to extremities with dried weeping from end of Vertical healed skin and very edematous 2nd toe on right foot. Nurse assessment on / indicated small drainage, monitor and leave open, instruct patient to keep clean and dry. Dried drainage leaking from right foot. On nurse note and assessment noted small amount of drainage, pitting and indicated no care provided. Nurse notes resident complains about pain, frowning when touching feet with 2-3 + . assessment indicated leakage from end of healed skin on right leg. care not provided. Aching, tight and throbbing pain. Two days prior to going to the emergency for to right foot, Hospice nurse note on / indicates scant amount of , 3 toes and skin weeping.. No signs of , care not provided, monitor and leave open air.

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On nurse note indicates resident going to emergency rule out . No measurements or staging were found on any assessments from admission. No documentation was found notifying ALF staff, family and doctors about .

Review of hospital notes found the resident was seen in the Emergency Department (ED) on / . She complained of foot pain, an open to right dorsum of forefoot. Positive for pain, , tenderness, warmth, deep to right foot. Differential diagnosis was , , foot . Upon arrival to hospital nurse notes foot looks and smells gangrenous. is size of a dollar bill, has foul odor, has green and yellow drainage, also areas around 2nd, 3rd, 4th & 5th toes had drainage around them, toes were " and discolored. The ED implemented , protocol. The resident was admitted to the hospital and a vacuum was placed to right foot for and open . Hospital discharge summary indicated the resident became very upset as the ALF / Hospice did not care for her foot. The note indicated eschar (tissue and/or scabs, blackish in color) on her foot what was not being cleaned properly. She had debrided.

Class II

0025 Resident Care - Supervision

Based on family interview, staff interview and record review, the facility failed to provide appropriate care and services related to supervision or assistance with bathing for 2 of 4 sampled residents (#1, #2) and failed to monitor residents skin which resulted in harm for 1 of 4 sampled residents. (#1)

The findings are:

1. Review of resident #1 Health Assessment dated indicated the resident had diagnosis which included and Post surgery Displaced foot with Skin . Resident #1 was alert and oriented but at times. The health assessment indicated Resident #1 needed assistance with ambulation and was independent with bathing and dressing, but contradicted this on page 5 where the assessment stated the resident needs assistance with showering and shampooing to be provided by self, staff and Hospice. Assistance with personal hygiene and self care provided by staff as needed.

Review of doctors orders noted the resident was receiving Hospice services for diagnosis of and to left foot.

Review of the facility monthly assessments dated noted resident as of ;

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needing staff assistance with bathing.

Review of Hospice Plan of Care noted an aide visits 3 times a week to provide baths. Review of the aides notes found the resident had been refusing baths. Further review of aide notes did not indicate the Hospice aide was communicating to ALF staff of refusing baths. Review of Hospice Skilled Nurse notes did not indicate the resident was refusing baths.

On at 1:20 pm, an interview was conducted with a family member of patient #1. The family member stated that patient #1 had old of her foot where she had to have skin . The family member indicated when patient #1 was admitted to the ALF she did not have an open to her foot. The ALF and Hospice did not tell me of the open area and her not wanting her baths. My mother said that Hospice and the facility did not bathe her and they didn't clean her on her foot or change the dressing.

Interview with Assisted Living Facility (ALF) Administrator on / at 8:30 AM indicated that Hospice staff did not tell us that the resident had been refusing showers for months. She said the resident never refused care by the facility. She said the Hospice staff never told them facility nor the family of the foot being bad. The administrator stated that there is an agreement between the resident and the hospice, but not with the facility.

Interview with ALF staff E on at 12:30 PM indicated hospice aide and nurse will come in and may come to see staff saying they visited. Hospice staff do not relate all of the things they did. Did not know of the to resident #1's foot, did not know of refusal to showers.

Interview with ALF aide staff C and D on at 12:45 PM both indicated resident #1 is out to the hospital. We didn't help with baths, resident #1 had Hospice aides come in 2 times a week to bathe her. Resident #1 got up in wheelchair per self and would go out to smoke. She was independent and we helped with dressing some of the time.

Further record review lacked documentation of the ALF assisting with baths and knowing that the resident was refusing baths from Hospice aides.

Review of Hospice Plan of Care (PoC) for certification period - found patient #1 was admitted to hospice with a diagnosis of . Patient #1 lives in an Assisted Living Facility (ALF) and requires assistance with care. Goals by the skilled nurse indicate care will be established that meets the patient needs two times a week. The nurse will provide instructions/reinforcement related to skin care and complications.

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Review of Hospice nurse visit notes found on 2+ to extremities with dried weeping from end of Vertical healed skin and very edematous 2nd toe on right foot. Nurse assessment on indicated small drainage, monitor and leave open, instruct patient to keep clean and dry. Dried drainage leaking from right foot. On nurse note and assessment noted small amount of drainage, pitting and indicated no care provided. Nurse notes resident complains about pain, frowning when touching feet with 2-3 + . assessment indicated leakage from end of healed skin on right leg. care not provided. Aching, tight and throbbing pain. Two days prior to going to the emergency for to right foot, Hospice nurse note on / indicates scant amount of , 3 toes " and skin " weeping.. No signs of , care not provided, monitor and leave open air.

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2. Review of resident #2 health assessment dated indicated diagnosis of with recurrent to lower extremities. The resident needed supervision with bathing. She was receiving Home Health service for Insufficiency. A skilled nurse visited 1 time a to assess skin.

Review of ALF Home Health Agency (HHA) record where HHA holds the resident plan of care (PoC) and logs visits and notes from agency lacked evidence of the PoC in the facility or any other notes from the HHA.

Interview with the Administrator on at 11:10 am indicated she is seen by HHA and has no

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at this time. The administrator was not sure of the services the HHA was providing or when they had visited last. The administrator indicated she didn't have the information in the building. She called the HHA and they brought the documentation to the facility. She said a detailed book from HHA is kept in the resident's we the facility has no right to see it or touch it.

Review of the skilled nurse (SN) note dated indicated the resident to have scabbed areas to lower left extremity, no stockings were on legs. Noted she couldn't reach her lower extremities and wonder how she bathed and applied cream to legs.

Review of SN visit dated I/ indicated multiple areas of dried . She indicated she got a bath this morning and the aide put a plastic bag over her leg while taking a bath so they were not washed. Educated the resident on need to wash and keep legs clean. SN spoke with ALF staff on importance of resident hygiene and needing to wash lower extremities. Expressed hygiene concerns.

Interview with aide C on at 12:30 indicated she revives HHA services and they were here Monday. She has open areas now. We assist with bathing when she needs it. She is independent and uses walker.

The ALF records lacked documentation of adequate communication between them and the HHA of care provided and lacked documentation of bathing provided by the ALF.

Class II

0028 Resident Care - Activities of Daily Living

Based on family interview, staff interview and record review, the facility failed to provide supervision or assistance with bathing for 2 of 4 sampled residents. (#1, #2)

The findings are:

1. Review of resident #1 Health Assessment dated indicated the resident had diagnosis which included and Post surgery Displaced foot with Skin . Resident #1 was alert and oriented but at times. The health assessment indicated Resident #1 needed assistance with ambulation and was independent with bathing and dressing, but contradicted this on page 5 where the assessment stated the resident needs assistance with showering and shampooing to be provided by self, staff and Hospice. Assistance with personal hygiene and self care provided by staff as needed.

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Interview with resident's daughter on at 1:20 PM indicated she did not know that her mother was refusing her baths. My mother said that neither Hospice nor the facility bathed her and they didn't clean her foot or change the dressing.

Interview with Assisted Living Facility (ALF) Administrator on / at 8:30 AM indicated that Hospice staff did not tell us that the resident had been refusing showers for months. She said the resident never refused care by the facility. She said the Hospice staff never told them facility nor the family of the foot being bad.

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Further record review lacked documentation of the ALF assisting with baths and knowing that the resident was refusing baths from Hospice aides.

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Class III