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SUMMARY STATEMENT OF DEFICIENCIES
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**Z816 - Background Screening-Compliance Attestation - 408.809(2)(a-c) FS**

Based on record review and staff interview, the facility failed to comply with background screening requirements by not having an Affidavit of Compliance (AOC) completed for 7 of 7 sampled employees. (Employee A, B, C, D, E, F, and G)

The findings are:
A review of employee files was conducted and showed no Affidavit of Compliance on file for Employee A hired ; Employee B hired ; Employee C (No date of hire produced), Employee D hired ; Employee E hired ; Employee F hired ; and Employee G hired .

On , 2017, at approximately 9:32am, an interview was conducted with the Employee E (Owner)via phone. He stated he was at work right then and would not be able to produce them, and to just write it up.

Unclassified

**0000 - Initial Comments**

On , 2017 through , 2017 an unannounced biennial survey including Limited Mental Health and Limited Nursing Services was conduted at La Grande Belle Assited Living Facility in Tallahassee FL. At the time of the survey, deficiences were identified.

**0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC**

Based on observation, record review and interview the facility failed to ensure that a resident with unstageable , was not admitted to the facility for 1 of 5 sampled residents. (#3)

Findings include:
Entrance conference held with facility owner on revealed no residents in the facility were receiving limited nursing services.

During tour of the facility at approximately 8:30am on , resident #3 was observed to have a bandage wrapping around his right foot. On at 11:35am an interview was conducted with the facility owner concerning the observation of the dressing on the right foot of resident #3. The owner stated that it was temporary and did not acknowledge the existence of any wounds.

Subsequent review of the medical record for resident #3 revealed a recent trip to the hospital on

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SUMMARY STATEMENT OF DEFICIENCIES
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for complaints of right foot pain. Assessment by the physician at the hospital, documented on a hospitalization discharge summary, revealed resident #3 had unstageable , to his right heel, right ankle, right lateral foot, and right anterior foot.
Resident #3 was accepted back to the facility with the wounds. The resident was receiving nursing services for treatment of his wounds through a local home health company.

On at 2:45pm an observation of care for resident #3, by a local home health agency staff nurse, was conducted. At the time of the observation, the resident was noted with unstageable wounds to right heel, right lateral foot, right ankle and right anterior foot (photographic evidence obtained).

On at 12:35pm an interview was conducted with the home health case manager for resident #3. She stated that she had spoken to the owner of the facility regarding the continued placement of the resident around , but the owner had not made any further contact with her about the issue.

On at 3:35pm and interview was conducted with the owner pertaining to the readmission of resident #3 after a new diagnosis of unstageable , . The owner stated that he had spoken to the case manager, but no decision had been made to discharge resident #3, and he confirmed that he did not currently have a nurse on staff at the facility.

Class III

**0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC**

Based on observation, record review and interview the facility failed to ensure that 1 of 5 sampled residents (#3) met requirements for admission and continued placement in the facility after the development of unstageable , .

Findings include:
Entrance conference held with facility owner on revealed no residents in the facility were receiving limited nursing services.

During tour of the facility at approximately 8:30am on , resident #3 was observed to have a bandage wrapping around his right foot. On at 11:35am an interview was conducted with the facility owner concerning the observation of the dressing on the right foot of resident #3. The owner stated that it was temporary and did not acknowledge the existence of any wounds.

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Subsequent review of the medical record for resident #3 revealed a recent trip to the hospital on for complaints of right foot pain. Assessment by the emergency at the hospital, documented on a hospitalization discharge summary, revealed resident #3 had unstageable to his right heel, right ankle, right lateral foot, and right anterior foot.
Resident #3 was accepted back to the facility with the wounds and there was no evidence that the facility had reassessed the resident's condition or sought alternate placement for the resident after this change in the resident's condition. The resident was receiving nursing services for treatment of his wounds through a local home health company.

On at 2:45pm an observation of care for resident #3, by a local home health agency staff nurse, was conducted. At the time of the observation, the resident was noted with unstageable wounds to right heel, right lateral foot, right ankle and right anterior foot (photographic evidence obtained).

On at 12:35pm an interview was conducted with the home health case manager for resident #3. She stated that she had spoken to the owner of the facility regarding the continued placement of the resident around , but the owner had not made any further contact with her about the issue.

On at 3:35pm and interview was conducted with the owner pertaining to the readmission of resident #3 after a new diagnosis of unstageable . The owner stated that he had spoken to the case manager, but no decision had been made to discharge resident #3, and he confirmed that he did not currently have a nurse on staff at the facility.

Class III

**0011 - Admissions - Discharge - 58A-5.0181(5) FAC**

Based on observation, record review and interview the facility failed to discharge a resident who no longer met the criteria for continued residency for 1 of 5 sample residents. (resident #3)

Findings include:
During tour of the facility at approximately 8:30am on , resident #3 was observed to have a bandage wrapping around his right foot. On at 11:35am an interview was conducted with the facility owner concerning the observation of the dressing on the right foot of resident #3. The owner stated that it was temporary and did not acknowledge the existence of any wounds.

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Subsequent review of the medical record for resident #3 revealed a recent trip to the hospital on for complaints of right foot pain. Assessment by the emergency at the hospital, documented on a hospitalization discharge summary, revealed resident #3 had unstageable to his right heel, right ankle, right lateral foot, and right anterior foot.
Resident #3 was accepted back to the facility with the wounds and there was no evidence that the facility had reassessed the resident's condition or sought alternate placement for the resident after this change in the resident's condition. The resident was receiving nursing services for treatment of his wounds through a local home health company.

On at 2:45pm an observation of care for resident #3, by a local home health agency staff nurse, was conducted. At the time of the observation, the resident was noted with unstageable wounds to right heel, right lateral foot, right ankle and right anterior foot (photographic evidence obtained).

On at 12:35pm an interview was conducted with the home health case manager for resident #3. She stated that she had spoken to the owner of the facility regarding the continued placement of the resident around , but the owner had not made any further contact with her about the issue.

On at 3:35pm and interview was conducted with the owner pertaining to the readmission of resident #3 after a new diagnosis of unstageable . The owner stated that he had spoken to the case manager, but no decision had been made to discharge resident #3, and he confirmed that he did not currently have a nurse on staff at the facility.

Class III

**0026 - Resident Care - Social & Leisure Activities - 58A-5.0182(2) FAC**

Based on observation and interview the facility failed to provide an ongoing activities program for each resident's needs, abilities and interest for 5 of 5 sample residents. (Resident #1, #2, #3, #4, #5)

Findings include:
On an observation was conducted for scheduled activities of a sing-a-long scheduled from 1:30pm to 3:00pm and movies of choice. The scheduled activities did not occur as posted on the activity board.

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On an observation was conducted for scheduled activities of BINGO from 12:30pm-2:30pm and movies of choice. The scheduled activities did not occur as posted on the activity board.

On at 10:30am resident #4 was interviewed regarding available activities, and he stated that there are board games, but he did not know how to play them.

On at 11:00am an interview was conducted with family member of resident #4 and she was asked about facility activities. She stated that she did have a concern because there weren't enough activities witnessed when she visited. She stated that her brother sits and watches television all day.

On at 11:15am an interview was conducted with resident #5, who is . He stated that there weren't any activities for people that he was aware of.

On at 4:00pm staff B was interviewed pertaining to the posted activities. She stated that the activities are not conducted by an outside source, and that staff were responsible for conducting the activities for the residents in the facility.

Class III

**0052 - Medication - Assistance with Self-Admin - 58A-5.0185 (3)**

Based on observation, interview and record review the facility failed to ensure unlicensed persons providing assistance with self-administered medications were properly trained to administer the medication for 2 of 2 sampled residents. (resident #1 and #4)

The Findings are:

On at 9:32am Employee B was observed assisting with medication to resident # 1 and #4. Employee B had already pre-poured medications prior to the residents being present and did not advise the resident of the medications being taken.

On at 9:33am an interview was conducted with Employee B. Employee B stated she had already pre-poured the medication for both residents because they were scheduled to have them during breakfast hours. She stated they normally get up for breakfast but that morning they wanted to sleep in.

Class III

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**0081 - Training - Staff In-Service - 58A-5.0191(2) FAC**

Based on record review and staff interview the facility failed to ensure and document direct care staff received the required training for the following in-service trainings. 2 of 8(Employee C and G) staff for Resident Rights, 5 of 8 (Employee's A, B, C, D, and F) Emergency Preparedness, 3 of 8 (Employee's C, F, and G) for Assistance with activities of daily living Staff's, 4 of 8 staff (Employee's A, C, E, and F) for Medication training and updates, and 3 for 8 (Employee D, E, and F) for . . . . Control.

The Findings are:

Review of Staff C records (No Hire Date provided). The record revealed no documented training for Resident Rights. Review of Staff's A, B, C, and D records (A Date of Hire , B Date of Hire . . . . . , C No Hire date provided, and D Date of Hire . . . . . ). The records revealed no documented training for Emergency Preparedness. Review of Staff's C and F records (C no hire date provided and, F Date of Hire . . . . . ) revealed no documented training for Activities of daily living. Review of staff the file for staff C revealed no documented records of any training. Staff members B, C, E, and F records revealed Medication training had expired (B , E , and F ) Review of staff's D and E records (D Date of Hire and E Date of Hire no hire date provided) revealed no documented training for . . . . Control.

An interview with Staff B was conducted on . . . . . at approximately 1:40pm. She stated if any items were missing it did not mean they did not do them, maybe they did not print them off but was unable to produce them.
An interview was conducted on , at approximately 9:32am, with the Employee E (Owner)via phone. He stated he was at work right then and would not be able to produce them and to just write it up.

Class III

**0082 - Training - / - 58A-5.0191(3) FAC**

Based on record review and staff interview the facility failed to ensure direct care staff received a one-time education course on and within 30 days of employment for 1 of 7 sampled employees. (Employee C)

The Findings are:

Review of employee C's (Resident Aid) with no hire date produced, revealed no evidence of and training.

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An interview was conducted on , at approximately 9:32am, with the Employee E (Owner)via phone. He stated he was at work right then and would not be able to produce them, and to just write it up.

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 the completion or First Aid and for 2 of 7 sampled employees (B and E).

The findings include:

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

Record review of the personnel file for employee E revealed First Aid and training for this employee expired .

On at approximately 11:00am, an interview was conducted with Employee B who works 7am -3pm. At that time, she was unable to produce an updated First Aid and card. She stated she would bring it the following day.
On at approximately 10:31am, a second interview was conducted with Employee B concerning her First Aid and card. She stated she did not have it that day, and would have to find it.

On , at approximately 9:32am, an interview was conducted with the Employee E (Owner)via phone. He stated he was at work right then, and would not be able to produce them, and to just write it up.

Class III

**0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC**

Based on record review and staff interview the facility failed to ensure and document direct care staff received the required medication training and updates for 4 of 8 staff reviewed. (B, C, E, & F)

The Findings are:

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Review of staff record of employee B showed their medication training had expired .
Review of staff record of employee C showed no evidence of medication training.
Review of staff record of employee E showed their medication training had expired .
Review of staff record of employee F showed their medication training had expired .

An interview was conducted on , at approximately 9:32am, with the Employee E (Owner)via phone. He stated he was at work right then and would not be able to produce them, and to just write it up.

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 comply with background screening requirements by not having an Affidavit of Compliance (AOC) completed for 7 of 7 sampled employees. (Employee A, B, C, D, E, F, and G)

The findings are:

A review of Employee A's (Date of Hire ), Employee B's (Date of Hire ), Employee C's (No date of hire produced), Employee D's (Date of Hire ), Employee E (Date of Hire ), Employee F (Date of Hire ), and Employee G (Date of Hire ) personnel file was conducted on , 2017. The Affidavit of Compliance was not observed in any of the employee files.

On , 2017, at approximately 9:32am, an interview was conducted with the Employee E (Owner)via phone. He stated he was at work right then and would not be able to produce them, and to just write it up.

Class III

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

Based on record review and interview the facility failed to conduct and record semi-annual weights for residents requiring assistance with activities of daily living (ADLs) per documentation of the 1823 for 2 of the 5 sampled residents. (#3, & #5).

Findings include:
On record reviews were conducted on residents #3 and #5 and per 1823 documentation,

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residents required assistance with ADLs. Further review of the residents' records revealed there were no semi-annual weights recorded by the facility.

On . . . at 12:00pm an interview was conducted with Staff B pertaining to residents' weights. Staff B stated that the residents get weighed when they go to the doctor, but staff do not weigh them at the facility.

Class III

**L241 - LMH - Records - 429.075(3-4); 58A-5.029(2) FAC**

Based on interview and record review the facility failed to maintain records for residents receiving limited mental health (LMH) services, and failed to ensure community living support plans for scope of service was available to assist residents with identified goals for 3 of the 5 sample residents. (Residents #1, #2, and #5)

Findings include:
A record review was conducted on for residents #1, #2, and #5, identified by owner as receiving LMH services. Upon review of the files there were no completed community living support plans, nor documentation of staff monitoring or assisting residents with identified activities or goals.

On . . . at 1:25pm an interview was conducted with staff B pertaining to her knowledge of the activities and goals for residents receiving LMH services. Staff member B stated that she knew the residents went to go to Veterans' affairs (VA) and Apalachee Center, but stated that facility staff don't conduct monitoring or assist LMH residents with activities or goals. Staff B stated that she was not familiar with a community living support plan.

On . . . at 1:35pm residents #1, #2 and #3, identified by facility owner as receiving LMH services, were interviewed regarding their community living support plan. Residents #1, #2 and #3 could all state their diagnosis but were not familiar with their identified activities or goals.

Class III

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

Based on record review and staff interview, the facility failed to ensure staff had updated Limited Mental Health training for 5 of 7 sampled employees. (B, C, D, E, and F)

The findings are:

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On . . . . . at approximately 8:30am, team leader requested a copy of the facility Admission/Transfer/Discharge log from employee B upon entrance to facility for survey. Employee B supplied team leader with log; however, it did not specify which residents were Limited Mental Health(LMH). When asked how the facility was able to identify which residents were LMH, employee B stated there was only one that she was aware of. Contact was made with Employee E (owner), who stated there were three to include residents #1, #2, and #5, and it was supposed to be documented in a facility binder.

Record review of personnel records for employees B, C, D, E and F revealed no documentation of Limited Mental Health training.

An interview was conducted on , at approximately 9:32am with the Employee E (Owner) via phone. He stated he was at work right then and would not be able to produce them, and to just write it up.

Class III

**N277 - LNS - Resident Care Standards - 58A-5.031(2) FAC**

Based on interview and record review the facility failed to maintain a copy of the healthcare provider order for limited nursing services and ensure nursing services were conducted and supervised per standard of practice for 1 of the 5 sampled residents. (# 3)

The Findings include:
On . . . . . at 11:35 am an entrance conference was held over the phone with the owner of the facility. Inquiry was made regarding the number of limited nursing service (LNS) and limited mental health (LMH) residents residing at the facility at that time. The administrator stated that he had no LNS residents and there were three LMH residents incorporated in his census.

During observation of the facility and residents, resident #3 was noted with a bandage wrapping around his right foot. Subsequent inquiry revealed that the resident has recently returned from the hospital with unstageable , on his right heel, right ankle, right lateral foot, and right anterior foot, and was actively receiving nursing services for these wounds through a local home health agency.

On . . . . . a record review was completed for resident #3. There was no order on the resident's chart for nursing services and no documentation that nursing progress notes or nursing assessments were being completed on the resident related to nursing services he was receiving.

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Class III

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

Based on interview and record review the facility failed to maintain records, which included nursing progress notes and monthly assessments for 1 of 5 sample residents. (Resident # 3)

Findings include:
Review of the medical record for resident #3 showed he had been sent to the hospital on . . . for right foot pain. Resident returned to the facility with multiple unstageable , on his right foot and was currently being seen by a home health nurse in the facility for care of these wounds.

The record for resident #3 did not reveal any nursing progress notes or nursing assessments for the resident or the nursing services he was receiving through home health for the wounds on his foot.

On at 1:15pm an interview was conducted with staff B pertaining to missing nursing progress notes and nursing assessments per standard of LNS residents. Staff explained that there were no additional documentation or records for resident #3.

Class III