STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932670	08/24/2017
NAME OF PROVIDER OR SUPPLIER **GRANDVIEW**	STREET ADDRESS, CITY, STATE, ZIP CODE **1706 OLIVE ROAD** **PENSACOLA, FL 32514**	

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

0000 - Initial Comments

A biennial licensure survey with Limited Nursing Services was conducted on - at Grandview Assisted Living Facility (license # 7371). At the time of survey, the facility did not meet requirements.

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

Based on observation, resident and staff interview, and record review, the facility failed to ensure the appropriateness of continued residency for 1 of 1 residents sampled for (#15). The facility readmitted resident #15 to the facility with an unstageable to the right heel.

The findings were:

An interview conducted with the Administrator and the Director of Wellness on at approximately 1:30 PM, revealed the facility did not have any residents with wounds receiving treatment from the facility or Home Health.

A record review completed for resident#15 revealed the resident was originally admitted to the facility on . He had a and was discharged to the hospital on with a hip. Following his hospitalization, he went to a nursing home for rehabilitation and returned to the facility on .

A review of the most current health assessment dated did not mention any wounds, but did have an order for Physical and Occupational , and Skilled Nurse. The assessment indicated resident #15 was alert and oriented, able to make his needs known, needed assistance with activities of daily living, and supervision with meals.

A record review of the facility progress notes dated noted it was brought to the facility's attention from home health that he had a blackened area on his right heel. The record and the facility did not have any other documentation of the or orders.

A review of the Home Health Agency's sign in log kept at the facility, revealed the last visit by the skilled nurse was on . The notes from this date indicated the was progressing well.

A review of the Home Health Agency records for resident #15, which are kept at the home health agency, indicated the start of care (SOC) was . The records indicated the agency nurse found the , on to the right heel of resident #15, was unstageable with

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measurements of 2.1 x 2 x 0. An order was received that day to paint with two times a day. Measurements taken by the home health nurse on were 1.8 x 2 x 0 and remained , according to the record.

An observation of care performed by the home health agency nurse on at 1:15 PM, for resident #15 discovered the measurement as 3 x 2.5 and . An interview with the resident indicated he received the at the hospital/nursing home and had it when he returned to the assisted living facility.

An interview with the Home Health nurse on at 2:15 PM, indicated they discovered the area on which was and staged as unstageable. She indicated the resident had been educated to apply to the area two times a day which he does. She stated, "home health nurses do weekly skin checks and measurements including staging." She indicated the was improving.

An interview with the Administrator on at approximately 2:30 pm confirmed the above findings.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, staff interview and record review, the facility failed to provide access to adequate and appropriate health care consistent with recognized standards related to control practices for 3 of 5 residents observed during assistance with self administration of medications. (#11,12,13)

The findings were:

On at 11:50 am, an observation during assistance with self administration of medications by medication technician (MT), staff B, noted the MT laying a glucometer that measured residents' sugars on the edge of the medication cart for resident #11 to use. The resident didn't have her glasses and kept asking the MT about how to operate the glucometer. The resident performed the by picking her finger to draw . Resident #11 had on her finger while handling the glucometer. After resident#11 used the meter, the MT placed it on the med cart without cleaning it.

Immediately following, the above observation, resident #12 came to the medication cart in the presence of the MT to perform his using the same glucometer. The MT didn't clean the meter before resident #12 used it. Resident #12 picked his finger to draw and used the meter to perform the . When he was done he placed it back on the med cart. The glucometer was not cleaned after resident #12 used it.

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Resident #13 came to the medication cart to perform her . . . . . using the same glucometer that had been used by resident #11 and #12. The resident kept handling the meter while she had on her finger. After the . . . . . was completed the MT placed the glucometer on the med cart for further use without cleaning it a third time.

An interview was conducted with the MT on at 12:30 PM, she indicated when all residents have completed their . . . . . using the glucometer she puts it in the med cart. When asked if she cleans it, she said, "sometimes I clean the glucometer with an wipe."

On at 1:20 PM, an interview with Nurse Consultant that teach the medication update training for the facility was conducted. She indicated that MT's are not trained to handle glucometers at all since they are not trained to assist residents with this. She indicated the nurses should handle this.

An interview with the Director of Wellness on at 9:15 am, indicated all residents are to have their own meters.

A review of the manufactor's manual indicated the meter is for single use by saying "The meter is for you to use in the home". The manual does not indicate to use for multiple residents.

A review of the new policy dated indicated for all residents to have their own meters and supplies and not to share. While waiting on meters, the staff are to clean the meters with Bleach wipes between residents.

Class III