STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967417	**09/15/2017**
NAME OF PROVIDER OR SUPPLIER **BEACON AT GULF BREEZE (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4410 GULF BREEZE PARKWAY GULF BREEZE, FL 32563**	

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

0000 - Initial Comments

An unannounced complaint survey for allegations contained within CCR#2017009294 and CCR#2017008821 was conducted from through at The Beacon of Gulf Breeze Assisted Living Facility, license #11456. Deficient practice was identified at the time of the survey.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, staff interview and record review, the facility failed to notify family members of changes in resident status for 3 of 7 sampled residents. (#1,2,4)

The findings are:

Resident #1: Record review found resident #1 was admitted on . The resident's most recent health assessment (Form 1823), dated , indicated the resident needed total assistance with activities of daily living and monitoring with eating, and was receiving hospice services.
On at approximately 8:45am an interview was conducted with the hospice nurse caring for resident #1. She indicated she cared for the resident 2-3 times a week and was at the facility all day on those days. She stated that resident #1 had bad circulation in her feet, and had developed some wounds on her feet from the circulation issue. She stated they had been treating the wounds from , 2017 through , 2017, and that the wounds were currently healed.
Record review of hospice notes and facility records lacked documentation that the family had been notified about the wounds on the feet of resident #1. Further review found that on resident #1 had complained of severe pain to her right leg. Hospice was called to come assess the resident. They came and received a telephone order dated to give , 10 milligrams every hour as needed for or pain, and 0.5 milligrams as needed for or pain. The resident was medicated for pain. The hospice record and the facility record lacked documentation that the family was called regarding the new order.

Resident #2: Review of an incident report for resident #2 found she had a left wrist on without pain. Hospice was called and they assessed it. On , the family requested an investigation. An x-ray was done on with the findings of no . Interview with the DON on at 9:45 am indicated the family should have been notified when the incident occurred.

Resident #4: Observation of resident #4 on at 9:45 am found she had a to her left lower leg. Record review indicated she received a new on for which a home health agency provided care.
Interview with the Director of Nursing (DON) on at 9:30 am indicated that resident #4 had

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sustained a and that home health was providing care for the . Review of the medical record for resident #4 lacked documentation that the family was called and notified of the resident injury. The DON said an incident report was completed, but she couldn't find the report.

Class III

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observation, staff interview and record review, the facility failed to provide needed assistance with eating for 2 of 7 sampled residents (#1, #5).

The findings are:

Resident #1: Observation of the breakfast meal was conducted on at 7:30am. Resident #1 had a plate in front of her, but she was not eating. Four staff were assisting other residents and did not attempt to assist resident #1. She ate approximately 50% of her meal. Observation on at lunch with the DON found resident #1 was served chicken, bread, greens, squash and lemonade to drink. The resident picked up her bowl of cole slaw and attempted to eat it with her tongue. Five staff were assisting and communicating with other residents, but did not attempt to assist resident #1. The resident sat without assistance using her fingers to eat. When brought to the attention of the DON, she had staff assist the resident, and the resident consumed 100% of her meal. The DON confirmed that resident #1 needed assistance with meals.

Resident #5: Observation of resident #5 during breakfast on at 8:00 am found her sitting a table not eating. Staff were busy assisting other residents. The staff did not attempt to assist her. She spilled water on the table and staff cleaned it up, and then removed her tray with approximately 50% of her food left on the tray.
Interview with DON on at 9:30 am indicated resident #5 required assistance with meals. She indicated that the resident did feed herself most of the time, but staff should have been monitoring and assisting her.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
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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 honor resident rights for 1 of 7 residents (#1) by failing to provide appropriate treatment as ordered by the physician.

The findings are:
Review of the medical record for resident #1 revealed a physician's order dated for the resident to wear when out of bed.
On from 7:30am until 12:30pm observation of resident #1 was conducted in the facility's dining/activity . Resident #1 was observed up in her wheelchair; however, the resident was not wearing the ordered on her feet.
A subsequent observation on at 1:30pm showed resident #1 still up in her wheelchair without on her feet.

Interview with the hospice nurse on at approximately 8:45am revealed that resident #1 had bad circulation in her feet which had caused the development of wounds on the resident's feet. She confirmed the resident had an order to wear while up, but stated the staff didn't always put them on her. She stated that the wounds on the resident's feet were currently healed.

Interview with the Director of Nursing on at approximately 9:30 am indicated the resident had skin concerns with both of her feet. She stated hospice had been treating the areas and that they were healed. She confirmed the resident was to wear while up.

Class III

0055 - Medication - Storage and Disposal - 58A-5.0185(6) FAC

Based on observation and staff interview, the facility failed to store medications in a secure manner for 1 of 2 units in facility (memory care unit).

The findings are:
Observation, while on tour of the memory care unit on at 7:45am, found the medication storage /nurses station door unlocked. Inside the medication 2 medication carts full of medications that were unlocked. Staff were not in eye site of the medication medication carts.
Interview with Licensed Practical Nurse C on at approximately 8:15am indicated he was administering medications.
Interview with the Director of Nursing on at approximately 8:20am confirmed the findings and indicated their policy was to have all doors locked when out of view and medication cart doors locked.

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Class III