STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922155	07/12/2018
NAME OF PROVIDER OR SUPPLIER **BELLE VISTA BLUFFS**	STREET ADDRESS, CITY, STATE, ZIP CODE **1138 ROSEMARY DRIVE** **LARGO, FL 33770**	

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

0000 - Initial Comments

Assisted Living Facility

On , 2018 a Complaint survey (CCR# 2018008167 and CCR#2018009786) was conducted at Belle Vista Bluffs. Deficiencies were identified at the time of the visit.

(license #7888)

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

Based on record review and interview, the facility failed to ensure 4 of 4 (#1, #2, #3, #4) resident records reviewed included an up to date health assessment form (1823) every 3 years or following a change in condition. Specifically, they failed to obtain a new 1823 following a need for Hospice services and the diagnosis of a .

Findings included:

During a record review for Resident # 1, it revealed they were admitted to receive hospice services in . A health assessment (1823) dated was reviewed in the chart. A new 1823 was not obtained for a change of condition when the resident was admitted to Hospice.

During an interview with the Administrator on at 10:32 AM, they stated when resident #1 went to another assisted living facility, hospice staff came and took the hospice chart with them, including the 1823 and all the records from hospice.

During a review of hospital records from a local hospital for Resident #2, they revealed they were brought into the emergency for /not eating X 2 days. The resident was diagnosed with a to the left hip measuring 3 X 1. There was also an unstageable to the sacral area measuring 5 X 9 cm with an observation of feces invading the area. Left heel unstageable measuring 2 X 1 cm. Right heel unstageable measuring 5 X 4.

During a record review for Resident #2, it revealed an 1823 dated . The 1823 did not indicate resident #2 had a or .

During an interview with the Administrator on at 10:45 AM, they stated the facility had no

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documentation for review regarding Resident #2's , . They stated a Home Health Company provided the care for Resident #2's , .

During a review of the resident record for Resident # 3, it revealed a health assessment (1823) dated . A new 1823 was required on .

During a review of a resident record for Resident #4, it revealed they were admitted to receive hospice services dated . A health assessment (1823) dated was reviewed in the chart. The 1823 stated they required medication administration. A new 1823 was not obtained for a change in condition when the resident was admitted to Hospice.

During an interview with the Assistant on at approximately 1 PM, they stated they would make sure Resident #3 received a new 1823. They stated they were unaware of why Resident #4 did not have a new 1823 when they were admitted on Hospice. They stated they do not employ nurses, the med techs assist with medications.

Class III

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

Based on observation and interview the facility failed to provide care and services appropriate to the needs of 1 (#3) resident who required repositioning and toileting every 2 hours.

Findings included:

Upon entrance to the facility at 8:00 AM, Resident #3 was observed in a Geri chair with a tray attached to it.
Observed at 9:13 AM Resident #3 still in geri-chair has breakfast plate on tray in front of them.
Observed at 9:27 AM in geri-chair with tray in front of them. Chair has been turned around to face the television.
Observed at 10:52 am Resident #3 has not been repositioned.
Resident #3 was not observed to be repositioned or changed/toileted until approximately 11:30 AM when they were put in their bed.

During an interview with Resident #3's physician on at 10:30 AM, they stated Resident #3 should be repositioned and toileted every 2 hours to prevent sores.

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SUMMARY STATEMENT OF DEFICIENCIES
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During an interview with the Administrator on at 11:06 AM, they stated their policy is to change or toilet residents every 3 hours. Residents' scheduled daily routine is the policy for the facility, it is in the book for the staff to follow. They do not have a written policy and procedure.

Class III

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

Based on observation, record review and interview the facility failed to provide an environment free from the use of physical for 1 of 8 (#3) residents currently residing in the facility. Specifically, they failed to obtain a physician,s order for 1/2 bed rails and used a chair with a locked tray for a resident that was not capable of removing it.

Findings included:

Observations of Resident #3 were conducted on during the hours of 8:00 AM and 2:30 PM, during a facility survey.

Upon entrance to the facility at 8:00 AM, Resident #3 was observed in a Geri chair with a tray attached to the front of it.
Observed at 9:13 AM - Resident #3 still in geri-chair, has breakfast plate on tray in front of them.
Observed at 9:27 AM - in geri-chair with tray in front of them. Chair has been turned around to face the television.
Observed at approximately 12:15 PM in their bed with 1/2 siderails in the up position at the head of the bed. Their geri-chair was observed to be pushed up against the foot of their bed.

During a record review for Resident #3, it revealed no documentation for or a physicians order for 1/2 bed rails.

During an interview with their physician on at 10:30 AM, they stated Resident #3 cannot push the tray off themselves due to a ( ) and being paralyzed on one side. Resident #3 uses the geri-chair all of the time.

During an interview with the Assistant Administrator on at approximately 1:00 PM, they stated they do not have a physicians order for Resident #3's 1/2 bed rails, but would get one. They stated the

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family ordered Resident #3's chair and were unaware they were not allowed to use it.

Class III

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

Based on record review and interview the facility failed to ensure 1 of 5 (E) staff whose records were reviewed received all required trainings. Specifically, they did not receive a 1- hour training in incident reporting and , neglect and , and also did not receive a 3 hour training in activities of daily living and behavioral needs.

Findings included:

During a review of Staff E's record on it revealed Staff E, whose date of hire was unavailable, did not have training in incident reporting, , neglect and , and activities of daily living and behavioral needs.

During an interview with the Assistant on at 2:30 PM, they stated they would ensure Staff E received the trainings.

Class III

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to maintain personnel records for 1 of 4 (C) employee records that were reviewed.

Findings included:

During a review of employee records on , no record was available for review for Staff C.

During an interview with the Assistant on at 10:15 AM, they stated, "I cannot find Staff C's record." "They have been employed here for 15 years but I have never seen their file."

Class III