STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964056	**07/30/2018**
NAME OF PROVIDER OR SUPPLIER **BELVEDERE COMMONS OF TAMPA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1513 WEST FLETCHER AVENUE** **TAMPA, FL 33612**	

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

0000 - Initial Comments

Assisted Living Facility

A Limited Nursing Services (LNS) Monitoring Survey was conducted at Belvedere Commons of Tampa Assisted Living Facility on . Belvedere Commons of Tampa Assisted Living Facility had deficient practice identified at the time of survey.

(License#: 8803)

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

Based on record review and interview, the Facility failed to:
1. Obtain a complete, updated Agency for Health Care Administration Form 1823 (AHCA 1823) upon a resident's significant change (admission to Hospice services); and,
2. Obtain an Interdisciplinary Care Plan, which specified those care and services provided by Hospice and those provided by the Facility and agreed upon by Hospice, Facility, and Resident (or Responsible Party) for two Hospice Residents (#2 and #3) of two sampled Hospice residents.

Findings Included:

A record review for Resident #2, conducted on , revealed that Resident #2 was admitted to Hospice services on . Resident #2's AHCA 1823, dated , did not include any services provided to Resident #2 on page 5 of the form. Resident #2 had a diagnosis and history of Parkinson's , , and . Resident #2 needed supervised assistance with eating and total assistance with ambulation, bathing, dressing, , toileting, and transferring. Resident #2 needed medication administration. Resident #2 had ongoing treatments to two wounds to the right foot. Resident #2's Interdisciplinary Care Plan ( ) did not include the provision of services for care or precautions. Resident #2 and AHCA 1823 page 5 did not indicate agreement by all Parties involved.

A record review for Resident #3, conducted on , revealed that Resident #3 was admitted to Hospice services on . The Facility did not obtain a new AHCA 1823 when Resident #3 had a decline in condition that necessitated admission to Hospice services on . Resident #3's AHCA 1823, dated did not list Hospice services as 'Nursing/ Treatment/ Services Required' on page 1. Resident #3's AHCA 1823, dated , did not include any services provided to Resident #3 on page 5 of the form. Resident #3 had a diagnosis and history of , Aphasia,

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and . . . . . . Resident #3 needed supervised assistance with eating and assistance with ambulation, bathing, dressing, ... , toileting, and transferring. Resident #3 had ongoing treatments to a non-stageable left hip . Resident #3's did not include the provision of services for care or . . . . . precautions. Resident #3's and AHCA 1823 page 5 had no documentation indicating agreement by all Parties involved.

An interview with Resident #3's Power of Attorney (POA), conducted on at 03:25pm, revealed that neither the Facility nor Hospice communicated to Resident #3's POA those services provided by Hospice and those services provided by the Facility.

During an interview with the Wellness Director, conducted on at 03:40pm, the Wellness Director acknowledged and confirmed that Resident #2 and #3's AHCA 1823s were incomplete. The Wellness Director acknowledged and confirmed that Resident #2 and #3's ICPs were missing required services and signatures of all Parties involved.

Class III

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

Based on observation, record review, and interview the facility failed to ensure that nursing services conducted and supervised with the prevailing standard of practice in the nursing community for three Residents (#1, #2, and #3) of three sampled residents admitted to the Facility's Limited Nursing Services (LNS).

Findings Included:

An observation of Resident #1's . . . . . , conducted on . . . . . at 01:00pm, revealed what appeared to be unsafe portable . . tank storage. Resident #1 had five small portable . . . tanks and four large portable . . . tanks in the closet, not secured in a rack or holder.

A record review for Resident #1, conducted on . . . . . , revealed that Resident #1was admitted to the Facility's limited nursing services (LNS) on . . . . . Resident #1 uses . . every night and as needed throughout each day. Resident #1 had a diagnosis of . . . . . , . . . , and . Resident #1's nursing documentation log did not contain any documentation regarding Resident #1 condition since . . . . . Resident #1 had unsafe portable . . . storage observed at 01:00pm.

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A record review for Resident #2, conducted on , revealed that Resident #2 was admitted to the Facility's LNS for two wounds on . Resident #2's nursing documentation log did not contain frequent documentation regarding Resident #2's or Resident #2's condition for every day treatment of the . The Hospice Nurse was scheduled every day Monday through Friday for the dressing changes. The Facility was responsible for the dressing changes as needed on Saturday and Sunday.

An observation of Resident #2's dressing change to the inner aspect of the right foot, conducted on at 02:15pm, revealed that the Hospice Nurse did not change gloves or wash hands after removing the soiled dressing and before cleansing the bed. The Hospice Nurse did not wash hands after cleansing the bed and before placing on clean gloves to apply a clean dressing. The Wellness Director, present during the dressing change, did not mention anything to the Hospice Nurse about potentially contaminating the and/or appropriate control practices during a dressing change to decrease the risk of potentially contaminating the .

A record review for Resident #3, conducted on , revealed that Resident #3 was admitted to the Facility's LNS for a non-stageable on . Resident #3's nursing documentation log did not contain any documentation since .

An observation of Resident #2's dressing change to the left hip, conducted on at 02:30pm, revealed that the Hospice Nurse did not change gloves or wash hands after removing the soiled dressing and before cleansing the bed. The Hospice Nurse did not wash hands or change gloves after cleansing the bed and before applying the ordered ointment. The Hospice Nurse did not wash hands after applying the ointment to the bed and before placing on clean gloves to apply the clean dressing. The dressing removed did not contain the date of the last dressing change. The Wellness Director, present during the dressing change, did not mention anything to the Hospice Nurse about potentially contaminating the and/or appropriate control practices during a dressing change to decrease the risk of potentially contaminating the .

Class III