STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11922155	R 09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLE VISTA BLUFFS	**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 Revisit to a 7/12/18 Complaint (CCR#2018009786 and CCR#2018008167) survey was conducted at Belle Vista Bluffs. Deficiencies were identified at the time of the visit.

(license #7888)

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

Based on observation and interview the facility failed to provide a safe and decent living environment, promoting dignity and free from neglect for 1 (#1) of 6 residents residing in the facility.

Findings included:

During a tour of the facility on at 9:45 AM Resident #1 was observed sleeping in their hospital bed with no sheets and the top covering at the end of the bed. Resident #1's bedside commode was sitting next to the bed with and feces in it.

During an interview with Staff A on at 9:55 AM they stated, "I don't know why there are no sheets. I just got here at 9:00 AM and it was like that."

Resident #1 was observed sitting in their wheelchair in the main common area at 10:43 AM. Resident #1 asked Staff A to use the . Staff A stated okay and unlocked their wheelchair. Resident #1 stated they could not walk. Staff A then walked away from Resident #1.

Resident #1 asked Staff A again to go to the 10:50 AM. Staff A said okay and walked away.

Resident #1 told Staff A they were and asked for a blanket at 11:04 AM. Staff A said, "What do you want? and then walked away.

During an interview with Staff A on at 11:10 AM, they stated they toilet the residents before lunch and Resident #1 had been toileted at 9:00 AM. They stated when Resident #1 asked to go to the , would wait a little more time because they would have to change them before lunch again.

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SUMMARY STATEMENT OF DEFICIENCIES
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During an observation on at 12:25 PM, Staff A was observed pushing Resident #3 in a Geri-chair. Resident #3 was screaming "n"o. Resident #3's left leg was between the seat of the chair and the reclining end. Staff A ignored the screaming and continued to push the chair. The reclining end was observed to be closing with the resident's left leg in it. Resident #3 continued to scream "no". The Surveyor intervened and advised Staff A that Resdent #3's leg was stuck. Staff A then repositioned Resident #3's leg, stating "she screams all of the time."

During an observation of Resident #1's 12:55 PM, the bed was still unmade with no sheets and the bedside commode was still sitting next to the bed with and feces in it.

Class III

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

Based on record review and interview the facility failed to ensure 1 resident (Resident #3) was provided assistance with self-administration of their medications as required under statute and rule and as prescribed by the physician.

Findings included:

During an interview with the Administrator on at 1:16 PM, they stated they did not have a noon medication pass but did have one at 1:00 PM.

During an observation of a medication pass conducted by Staff A and the Administrator on at 1:19 PM for Resident #3, Staff A opened the pill pack. The Administrator told Staff A to open the capsule and sprinkle it on the resident's ice cream. The Administrator opened the capsule, got a spoon of ice cream and sprinkled the contents of the capsule onto the spoon of ice cream and put the spoon into Resident #3's mouth.

During a review of Resident #3's medication orders it revealed the medication was ordered as , sprinkle 125 MG, take at 12:00 PM.

During an interview with the Administrator on at 1:20 PM, they stated they always give Resident #3 their medication this way because they can not take it by themselves. The Administrator stated neither they nor Staff A are a nurse. They also stated they were not aware the medication was ordered for 12:00 PM.

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SUMMARY STATEMENT OF DEFICIENCIES
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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 3 (E) staff whose records were reviewed received all required trainings. Specifically, they 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 activities of daily living and behavioral needs.

During an interview with the Administrator on at 12:30 PM, they confirmed Staff E did not have their 3 hour training in activities of dialing living and behavioral needs.

Class III