STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968987	03/14/2019
NAME OF PROVIDER OR SUPPLIER **ASTORIA ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **319 ELDRIDGE AVE** **ORANGE PARK, FL 32073**	

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

0000 - Initial Comments

On , , through , , complaint surveys (CCR #2018007832, CCR #2018014527 & CCR #2018003875) were conducted at Astoria Assisted Living Facility. Deficient practice was identified during the surveys.

0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC

Based on observation, resident interview, clinical record review, staff interview and policy and procedure review, the facility failed to ensure one of six sampled residents met the minimum criteria for admission, when Resident #1 had an , .

Reference:
NPUAP Pressure Injury Stages | The National Advisory Panel
https://www.npuap.org/resources/educational-and.../npuap-pressure-injury-stages/
Pressure Injury: Obscured full-thickness skin and tissue loss.
Full-thickness skin and tissue loss in which the extent of tissue damage within the cannot be confirmed because it is obscured by or eschar. If or eschar is removed, a or pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without or fluctuance) on the heel or should not be softened or removed.

The findings include:

During an interview with Resident #1 on at 11:30 am in the lobby of the facility, he was observed to have and a blue foam , applied to his left . Resident #1 stated he has a on his heel. He stated he it developed at a local hospital when he had a on his / . A nurse comes to change the once a week. He was not sure if it was healing or not because he cannot see it.

Review of the clinical record revealed the health assessment form dated read: " to left heel" (Photographic evidence obtained).

Review of the clinical record revealed no care progress notes.

Review of the facility nursing notes read: " 2:15 pm resident return to facility today from [nursing home]. Resident presented with to left heel. Home health orders given to [third party provider of care] for care and / (, / , / ,).

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ARNP (Advanced Registered Nurse Practitioner) notified of resident return and ." A note dated read: "3:45 p seen by ARNP new care frequency orders received, forward to HH (home health)." Note dated read: "Seen on by podiatry" (Photographic evidence obtained).

Review of the physician's order dated revealed the following notation: Telephone order per ARNP, Home Health registered nurse evaluation, / evaluation and treat. Diagnoses: left heel /strengthening.

During an interview with Health and Wellness Director (HWD) on at 1:30 pm, she stated that Resident #1 does have a on his left heel. His care is provided by a local home health agency. Resident #1 was receiving rehabilitation at a local nursing home and that facility called her to tell her he was ready for discharge. She stated that the nursing home was very insistent that he be discharge to this facility immediately. She felt pressured to take him. She was shown Resident #1's health assessment and asked if she knew that he had an to his left heel. She stated she was aware of it. She stated she knew she could not admit residents with a or higher

care progress notes were requested. She stated she did not have any and would call the home health agency that provided the care to the resident and request them.

Review of the care progress notes provided by the home health agency providing care to Resident #1 revealed Resident #1 was seen on , , , and . Each assessment included a description of the that read: Left heel/ /, . bed: , bed color/percentage: beefy red yellow, edge: fibrotic/scarred; Peri skin: excoriated; Drainage: amount-scant, color- , odor-none. measurements: Length 3.2centimeters (cm) x Width 3.0cm x Depth 0.2cm. cleansing/ change per care plan. care per care plan patient tolerated well (Photographic Evidence Obtained).

During a care observation on at 3:47 pm with the care nurse from the home health (HH) agency provider, Resident #1 stated that his was not healing as fast as he would like. Resident #1 gave verbal permission to photograph the on his left heel (Photos obtained). The , was removed from his left and revealed the on the was discolored with drainage from the . The inside of the was encrusted with drainage seeping through from the . The outside of the , was covered with dirt and debris. The HH nurse stated that the was still because she could not see the depth of the

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due to the . She measured the and stated it was 3.3cm x 2.2 cm x 0.2 cm.

During an interview with the HH nurse on at 4:07 pm she stated that if she could see the whole bed she would have to stage the at a due to the observed depth around the edges of the . The went into the lower levels of the fascia, so it would not be considered a .

During an interview with the HWD on at 4:20 pm, she stated that she should have not re-admitted Resident #1 from the nursing home when the nursing home wanted to discharge him. She stated it was her fault that she did not catch it when the health assessment stated he had an to his left heel.

Review of the policy and procedure for Admission/Retention/Discharge Policy dated revealed the following: It is the policy of this facility to admit and retain appropriate residents at all times, in keeping with State of Florida regulations. Therefore the administrator and staff of this facility will abide by the following criteria for admission and continued residency in this facility: J. The individual does not have any or 4 . (Photographic Evidence Obtained)

Class III

0008 - Admissions - Health Assessment - 429.26( ) FS; 58A-5.0181(2) FAC

Based on record review, staff interview and policy and procedure review the facility failed to ensure the Health Assessment form 1823 was complete and accurate for two residents (#1 and #2) out of five sampled residents.

The findings include:

Review of the Health Assessment form 1823 for Resident #1 dated: revealed page number two, three, four and five did not have the resident's name on it. Page number five was blank in section 3, Services Provided to Resident (Photographic evidence obtained).

Review of the Health Assessment form 1823 for Resident #2 revealed it was not dated. Page number five of the form was blank in section 3, Services Provided to Resident (Photographic evidence obtained).

During an interview with the Health and Wellness Director on at 4:50 pm, she acknowledged that the forms were blank and some were missing information. She stated she tries to audit the forms

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but does not always have the time.

Review of the policy and procedure for admission/retention/discharge policy dated revealed it read: It is the policy of this facility to admit and retain appropriate residents at all times, in keeping with State of Florida regulations. In all cases for admission to this facility the Administrator or a designee will conduct a comprehensive assessment to determine whether the individual is appropriate for admission to an assisted living facility. (Photographic Evidence Obtained)

Class III

0031 - Resident Care - Third Party Services - 58A-5.0182(7) FAC 429.255(1)(b). FS

Based on observation, resident interview, clinical record review, staff interview and facility policy and procedure review the facility failed to ensure the third party provider for one resident out of five sampled residents (Resident #1) had coordinated care and documented in the facility clinical record.

The findings include:

During an interview with Resident #1 on at 11:30 am in the lobby of the facility, he was observed to have and a blue foam applied to his left . He had no sock on his . Resident #1 stated he has a on his heel. He got it at a local hospital. A nurse comes to change the once a week. He was not sure if it was healing or not because he cannot see it.

Review of the clinical record revealed the health assessment form dated read: " to left heel" (Photographic evidence obtained).

Review of the clinical record revealed no care progress notes.

Review of the facility nursing notes read: " 2:15 pm resident return to facility today from [nursing home]. Resident presented with to left heel. Home health orders given to [third party provider of care] for care and / (, , / ,). ARNP (Advanced Registered Nurse Practitioner) notified of resident return and ." Note dated read: "3:45 p seen by ARNP new care frequency orders received, forward to HH (home health)." Note dated read: "Seen on by podiatry" (Photographic evidence obtained).

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Resident #1's record contained a physician's order dated . . . . . which it read: Telephone order per ARNP, Home Health registered nurse evaluation, / . evaluation and treat. Diagnoses: left heel /strengthening.

During an interview with Health and Wellness Director (HWD) on at 1:30 pm, she stated that Resident #1 does have a , ... on his left heel. His . . . care is provided by a local home health agency. care progress notes were requested. She stated she did not have any and would call the home health agency that provided the . . . care to the resident and request them.

During an interview with the HWD on . . . . . at 4:20 pm, she acknowledged that she should have the care notes from the third party provider in the facility clinical record for Resident #1. Review of the facility policy and procedure for Third Party Provider Services dated . . . , ... revealed that: "In instances when residents or their representatives arrange for third party services, the facility administrator or designee, when requested by residents or representatives, will take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals. These actions shall be documented in the resident's record" (Photo Evidence).

Class III