Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968024	A. BUILDING: _____ B. WING _____	01/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE SENIOR LIVING AT ST PETERSBURG	3479 54TH AVE N SAINT PETERSBURG, FL 33714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint (complaint numbers 2021000827 and 2021001502) survey was conducted on at Noble Senior Living At Saint Petersburg. The facility had deficiencies at the time of survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of ... or ... or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such ... or ... The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident ' s representative or designee of the need for health care services and must assist in making ... for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident ' s representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of	A 025		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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A 025	Continued From page 1 resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on attempted record review, interview and observation, the facility failed to maintain supervision and oversight necessary for one (Resident #1) resident which resulted in injury and hospitalization of the resident. Additionally, the facility failed to ensure that residents' records were onsite and included all significant changes for one (Resident #1) of six residents sampled, which prevented a thorough investigation from occurring. Findings Included: An interview was conducted on at	A 025		

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A 025	Continued From page 2 12:55p.m. with the Resident Care Director (RCD), when asked about an incident that occurred with Resident #1 on . . . . . she stated "she jumped out the window Sunday night the 24th, we had made rounds, heard a noise, she must have pushed the window and the latch came open and it looks like she stood on the ledge and slid off falling to the pavement". The RCD further stated that Maintenance placed locks on all the second floor windows on Monday morning to prevent the windows from being opened. An interview was conducted on . . . . . at 12:40p.m. with Resident #1's family member via telephone. The family member stated the facility had called him on around 9:30p.m. and said the resident had . . . . out of a window and he drove to the facility. The family member further stated Resident #1 was laying on the grass in the front of the building and when he asked her what happened she stated that she wanted to get out of the facility because she had to take care of two children, so she jumped out of the window. A record review was conducted on of a form titled _, ... Progress Note signed by an Advanced Registered Nurse Practioner (ARNP) of _, . . . , dated . . . . in the section titled History of Present Illness stated "met with resident who thinks she has small children [at] home and wants to leave" (photographic evidence obtained). A tour of the second floor was conducted on at 1:08p.m. with the RCD, 1 of 2 windows (the smaller window) in . . . . . did not have a lock on the window and could be opened by a resident and 2 of 2 common area windows at the east end of the hallway did not	A 025		

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A 025	Continued From page 3 have a lock on the windows that could be opened by a resident. The Maintenance worker arrived at 1:10p.m. to join the tour and stated he was out of locks, the RCD then told Maintenance to get the credit card and get more locks. photographic evidence was obtained revealing the window resident #1 was thought to have opened, area where resident #1 landed, side view of window thought to have been opened by Resident#1 and the type of lock to prevent the windows from being opened. A record review of the staff schedule was conducted on for the 3p.m. to 11p.m. shift of and revealed 6 staff scheduled to be in the facility (photographic evidence obtained). An interview was conducted with the RCD on at 3:20p.m. and she stated that 4 staff were working the memory care unit on from 3p.m. to 11p.m. An interview was conducted on at 3:36p.m. with Staff G who stated that there were 3 staff members working the memory care unit from 3p.m. to 11p.m. on . An attempted record review was conducted on for resident #1's medication observation record (MOR). The MOR was not present in the facility. During an interview with the Resident Care Director (RCD) on at 2:30p.m. when asked where Resident's #1 MOR was, she stated that another State Agency had been in the facility the day before and had taken resident's original MOR and other internal investigative documents and forms with them and no copy had been made	A 025		

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A 025	Continued From page 4 prior to the other State Agencies departure. The RCD further stated that she had contacted the staff person with the State Agency and was told that the MOR and other documents would be emailed to her no later than . . . . . The RCD stated when she receives that information via email, she will forward those documents to this surveyor. A limited record review of Resident #1 MOR was conducted on . . . . . at 3:30p.m. and revealed that Resident #1 had not received the following prescribed medications: * , 5 milligram (MG) Tablet (TAB), take 1 tablet by . . . . daily in morning for . , ... 8a.m., not marked as given on at 8 a.m. * . , ... 8MG Tablet, take 1 tablet by twice daily for , 12p.m. and 8 p.m., not marked as given on 12p.m. . . . . and 12p.m. on * , 25MG , Capsule (CAP), take 1 CAP by . . . twice daily 8a.m. and 5p.m., not marked as given at 8a.m.on and . . . . . and not marked as given at 5p.m. on * 1000MCG Tablet, take 1 tablet by . . . once daily 8a.m., marked as not given on and * , 0.5MG Tablet, take 1 tablet by . . . in the morning for . . , /agitation 8a.m., marked as not given on and * , 1MG Tablet, take 1 tablet by at bedtime for . , /agitation (must reorder) 8p.m., marked as not given on	A 025		

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A 025	Continued From page 5 * 5MG Tablet, take 1 tablet by once daily for 8a.m., marked as not given on and * Low Dose 81MG Tablet, take 1 tablet by daily 8a.m., marked as not given on and * 10MG TAB, take 1 tablet by daily at bedtime for 8p.m., marked as not given on * TAB, take 1 tablet by daily at bedtime for Exptrapyramidal Symptoms (EPS) 8p.m., marked as not given on * ( ) 10MG TAB, take one tablet by twice daily 8a.m. and 8p.m., marked as not given on 8a.m on and at 8a.m. and 8 p.m. * 1MG TAB, take 1 tablet by daily 8a.m., marked as not given on and * 500MG TAB, take ½ tablet with meals twice a day for 8a.m. and 8p.m., marked as not given on and at 8a.m. An interview was conducted on at 3:22p.m. via telephone with the RCD and when asked what the facility has done since the incident with Resident #1 the RCD stated we have increased the hourly checks to every half hour, told the staff to be really aware of the residents and put the locks on all the windows.	A 025		

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A 025	Continued From page 6 Class II	A 025		