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
	AL11965303	A. BUILDING: _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBINA MANOR	820 15 TH STREET N. SAINT PETERSBURG, FL 33705

(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 #2022000366 and 2022001113) in conjunction with a generator monitoring survey was conducted at Albina Manor Assisted Living Facility on . . . . . Deficiencies were identified at the time of survey.	A 000		
A 011 SS=D	59A-36.006(5) FAC Admissions - Discharge (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care practitioner, the resident must be discharged in accordance with Section 429.28, F.S. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide and appropriate discharge for one Resident (#1) of two sampled. This action left the resident homeless with nowhere to go. Findings Included: A record review conducted on . . . . revealed a 45-day discharge notice dated in Resident #1's chart. The effective date of discharge was from to . The discharge notice was not signed by Resident #1. A record review conducted on . . revealed a letter dated stated the following: "[Resident #1] refuse to move out of ALF [assisted living facility]. He didn't call any other ALF for placement. He was given three to call. On the facility physician came to see all residents. The Administrator asks to place resident in hospital psych unit for eval. The doctor say he can't do that because it is not mental health issue more behavior problem.	A 011		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 011	Continued From page 1 Administrator informed [Resident #1] that he can't stay at assisted living facility no longer. All his medication and belonging was given to [Resident #1] with copy of his 45 day note. Resident left ALF to find place to stay at 4:00 PM." A record review conducted on . . . . . of Resident #1's lease revealed the following. Page 9 section 7. Resident Discharge, subsection 7.A.2 states the following: Upon determination by the Administrator or Health Care Provider that the resident needs services beyond those the facility is licensed to provide, the resident or next of kin, legal representative, or the agency acting on the Resident's behalf, will be notified in writing that the resident must make arrangements for immediate transfer to an appropriate care setting. In the event the Resident has no person to represent him/her, the Facility acting for the Resident, will transfer the Resident to an appropriate care location and shall make a referral to an appropriate social service agency for placement action. During an interview with the administrator conducted on at 11:57 AM the Administrator stated the following, "I gave him three different numbers to ALF's to move to, but he did not call. If I would call an ALF that I need to evict who is going to take him when I tell them everything he does. It is better if the resident called. We could not him because he was not . . . . . is the end of the 45-day notice and he would not move out. I tell him he must move out he cannot stay here. I gave him all the tools to move. I gave him his meds and a copy of all the paperwork, and I told him to go to the [local hospital's emergency room] and tell them he doesn't feel well. I did not want to call the police to evict him. I told him where the	A 011		

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A 011	Continued From page 2 homeless shelter is down about a . . . , that he could go there." An interview with Resident #4 conducted on at 1:20 PM he stated, "[Resident #1] left in the late afternoon. He came a couple of times to get in. The door was locked. He eventually off. I don't know what happened to him after that. An interview with Resident #5 conducted on at 1:27 PM he stated," It was late afternoon when he [Resident #1] left. He was looking in the windows. I went out to him. He was looking lost. He needed somewhere to go. I told him, pointing down the street toward St. Anthony's to go there to get help. I am not aware of him coming . I never saw him again. Class III	A 011		