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
	AL11966458	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TAMPA ASSISTED LIVING	5010 40 STREET NORTH TAMPA, FL 33610

(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 Assisted Living Facility A complaint survey, CCR# 2012007352, was conducted on ..... and ..... The Central Tampa assisted living facility had deficiencies found at the time of the visit.	A 000		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of	A 030		

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A 030	Continued From page 1	A 030		

the Florida Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside.
(h) Pursuant to Section 429.41, F.S., the use of physical shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the

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A 030	Continued From page 2	A 030		

resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical

429.28 Resident bill of rights.-
(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:
(a) Live in a safe and decent living environment, free from and neglect.
(b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
(c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents.
(d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or

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A 030	Continued From page 3	A 030		

attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a , his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally , the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right

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A 030	Continued From page 4 includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to keep safe one of three residents (#1) sampled in the secured unit. The resident (#1) successfully eloped from the facility through an inadequately secured window and was not able to be located and returned safely. The resident (#1) was later found Findings include: On at 3:48 p.m. the owner of the facility contacted the Assisted Living Facility Supervisor at the Agency Field Office by telephone. The owner was calling to report that Resident #1 who had eloped from the facility on had been found in a nearby river at a public park on . The owner reported that they and Resident #1's Guardian had been contacted by the police however the police could not conclusively identify the body until positive identity could be established by the medical examiner. The owner went on to state that the Guardian had contacted the facility on to confirm that the Medical Examiner's office had identified the drowned body as that of Resident #1. A record review on of Resident #1 ' s Health Assessment Form AHCA 1823, which was dated indicated that the Resident was admitted to the facility with a diagnosis of defects, and . The AHCA Form 1823 also	A 030		

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A 030	Continued From page 5	A 030		

indicated that Resident #1 required general daily oversight in which staff was to observe daily the resident ' s wellbeing and whereabouts as well as remind the Resident of important tasks.
A record review on : of Resident #1 ' s chart revealed an " Elopement Risk Assessment " document, dated , in which Resident #1 was identified as a risk for elopement. The assessment scores areas such as orientation, unusual emotional behavior, activity, mobility and medication. A score above 9 indicated that the resident is an elopement risk. In this assessment the resident was evaluated by facility staff to have a score of 13.
A record review on : of Resident #1 ' s chart revealed a Behavioral Health Consultation, dated , in which Resident #1 was referred for evaluation because of difficulty adjusting as well as elopement behaviors.
The above records and documents clearly established and indicated upon admission to the facility that Resident #1 was an elopement risk.
A telephone interview with Resident #1 ' s Guardian was conducted on : at 4:00 p.m. The guardian stated that she was appointed guardian because Resident #1 was unable to make sound decisions. The Guardian also stated that Resident #1 was " very trusting and this got him into trouble. " The Guardian also indicated that Resident #1 was placed into this facility because he had a history of eloping from other facilities and it was felt that Resident #1 would be safe at this location since it was " secured. "
A general tour of the facility was conducted on . During the tour, the surveyor inspected the window in Resident #1 ' s . The surveyor observed the window to be secured on each side by a limiting device which allowed the window to be partially opened in order to allow

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A 030	Continued From page 6	A 030		

fresh air in. This limiting device was secured to the window frame by a screw. The surveyor tested the screw and noted that it turned quite easily allowing anyone to remove the device from the window frame.
A record review of the Resident Observation Log on [redacted] and dated [redacted] at 7:30 a.m. indicated that " Staff reported that Resident (#1) was missing from the facility. " The report goes on to indicate that a facility wide search was conducted inside and outside, resident was not found, local police were notified and guardian was notified. The observation log indicated that the [redacted] stated that Resident #1 went out the window. Resident #1 ' s [redacted] was interviewed by the surveyor however; the surveyor determined that the [redacted] was not a reliable witness.
A telephone interview was conducted on [redacted] at 5:30 p.m. with Staff #B who was the direct care staff person on duty during the time Resident #1 eloped. Staff #B stated that " the facility was aware of Resident #1 ' s elopement issues and that they watched out for him. " Staff #B stated that he observed Resident #1 outside his [redacted] approximately 5:45 a.m. on [redacted] and engaged the resident in small talk. Staff #B noted that Resident #1 was fully dressed. Staff #B states that after a few minutes talking, Resident #1 went back into his [redacted] Staff #B indicated that it became apparent that Resident #1 was missing when he did not come to the dining [redacted] he usually did by 7:30 a.m. Staff #B then indicated he went to Resident " 1 ' s [redacted] observed the window screen on the floor of the [redacted] Staff #B then informed Staff #A that Resident #1 was missing.
An interview was conducted on [redacted] at approximately 10:30 a.m. with the facility administrator and psych nurse. The Psych Nurse

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A 030	Continued From page 7	A 030		

confirmed that Resident #1 had short term memory loss and had exit seeking behavior but seemed to stop trying to go out the front door. The Psych Nurse also indicated that the resident seemed happy and got along well with his roommate. Administrator stated that the windows are not permanently secured because the fire department said there must be a second egress in case of an emergency. She also indicated that she was not aware that the screws could be easily taken out of the locking device. The Administrator acknowledged that this is what Resident #1 did.

A telephone interview with the local fire inspector on 07/10 2:30 p.m. confirmed that a second egress is usually necessary in case of a fire however; he stated that this facility had a fire suppression system approved by the fire department and this facility was exempt from the second egress provision and they can secure the windows. A document entitled Fire Prevention Inspection Report/Invoice #95858 was reviewed by the surveyor on 07/10 Report/Invoice was issued to the facility on 02/01 report indicated that the facility had to perform maintenance service on its fire sprinkler/supression system. A follow up Report/Invoice #95864 also reviewed by the surveyor on 07/10 that a follow up inspection done on 02/07 cleared the previous deficiency and declared the fire sprinkler/suppresion system to be operating satisfactorily. The fire inspector stated that he would send the facility a letter informing them that the facility windows can be secured.

The Fire Prevention Inspection Report is proof that the facility had a working fire supression/sprinkler system in place at the time Resident #1 eloped from the inadequately secured window. Additionally, the interview with

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A 030	Continued From page 8 the fire inspector confirmed that the facility windows located in the secured unit could have and should have been secured to prevent egress. Class II	A 030		
A 152	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, chest or other furniture designed for storage of personal effects; 4. A table, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident to be used in the event of an emergency.	A 152		

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A 152	Continued From page 9 (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be This Statute or Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure that the windows in the secured unit were properly secured in that the limiting devices placed on the windows to prevent them from being fully opened were working as intended by their installation. Findings include: During a general tour of the facility conducted on [redacted] at approximately 9:15 a.m., the window to Resident #1's [redacted] inspected as well as three other resident windows on the first floor of the facility. The surveyor observed that the windows were fitted with with a limiting device held in place by a thumbscrew as a means of preventing the windows from being fully opened. As the [redacted] in question are located in a secured facility with exit doors locked with entry/exit gained by keypad device, it would indicate that the windows would equally need to be secured to ensure the safety of the residents, in keeping with the intent of the unit. The surveyor tested the window limiting device and found that it was easily removed and as such	A 152		

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A 152	Continued From page 10 not functioning as intended to prevent the window from being fully opened. During an interview with the Administrator on at approximately 10:30 a.m. the Administrator indicated that she was not aware that the screws could be easily taken out of the locking device. Class III Pattern	A 152		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

. 2012

Administrator
Central Tampa Assisted Living
5010 40 Street North
Tampa, FL 33610

Dear Administrator:

Re: **CCR# 2012007352**

This letter reports the findings of a complaint survey that was conducted on . 2012, and . 2012, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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