

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                          |                          |                               |
|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                          | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |                          |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                               |
| A 000                                                      | Initial Comments<br><br>Assisted Living Facility<br><br>A complaint survey, CCR# 20120010308, was<br>completed on _____<br><br>The Georgia's Place, assisted living facility, had<br>deficiencies found at the time of the visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | A 000                                                                          |                                                                                                                          |                          |                               |
| A 050                                                      | 58A-5.0185(1) FAC Medication - Self<br>Administered Medications<br><br>Medication Practices.<br>Pursuant to Sections 429.255 and 429.256, F.S.,<br>and this rule, licensed facilities may assist with<br>the self-administration or administration of<br>medications to residents in a facility. A resident<br>may not be compelled to take medications but<br>may be counseled in accordance with this rule.<br>(1) SELF ADMINISTERED MEDICATIONS.<br>(a) Residents who are capable of<br>self-administering their medications without<br>assistance shall be encouraged and allowed to<br>do so.<br>(b) If facility staff note deviations which could<br>reasonably be attributed to the improper<br>self-administration of medication, staff shall<br>consult with the resident concerning any<br>problems the resident may be experiencing with<br>the medications; the need to permit the facility to<br>aid the resident through the use of a pill<br>organizer, provide assistance with<br>self-administration of medications, or administer<br>medications if such services are offered by the<br>facility. The facility shall contact the resident's<br>health care provider when observable health care<br>changes occur that may be attributed to the<br>resident's medications. The facility shall<br>document such contacts in the resident's<br>records. | A 050                                                                          |                                                                                                                          |                          |                               |

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0000

GBNV11

If continuation sheet 1 of 16

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |  |                               |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 050                                                      | <p>Continued From page 1</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on observation, record review and<br/>interview, the facility failed to assure 1 (Resident<br/>#2) of 5 residents sampled whose medication<br/>orders were reviewed and medications reconciled<br/>had the required self administration order for<br/>..... and ..... or communication when<br/>the order should have been rescinded, placing<br/>the resident at risk for misdosing herself or using<br/>the prescribed ..... for unintended use<br/>(potential overdose).</p> <p>Findings include:</p> <p>Review of Resident #2's file revealed she had<br/>been admitted to the facility on ..... following<br/>an overdose of medications while living<br/>independently. The most recent health<br/>assessment dated ..... revealed the resident<br/>needed medication administration.</p> <p>Further review revealed the resident was ordered<br/>..... 100units ..... nightly<br/>before bed. There was no documentation found<br/>that assessed the resident as capable of<br/>administering her own ..... or 3x day .....<br/>..... (glucose monitoring) which she told the<br/>surveyor during an interview ..... at<br/>approximately 9:30 a.m.) that she did on her own.</p> <p>Observation of the ..... for the resident<br/>revealed ..... was available for use for the<br/>resident and further review of the medication<br/>observation record revealed it was signed off as<br/>given on a daily basis by non licensed staff.</p> <p>Further interview of the resident revealed the staff<br/>gave her the ..... flex pen every night and<br/>observed her move the flex pen to the correct unit</p> | A 050                                                                          |                                                                                                                          |  |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                          |                          |                               |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                          | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |                          |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                               |
| A 050                                                      | Continued From page 2<br><br>position and then watched her inject the .....<br>She said her ..... sugar measured between<br>70-135 which she said was stable for her. She<br>also said she had been diagnosed as being<br>..... at approximately 18 months of age and<br>had been on ..... as long as she could<br>remember. Further interview with the resident<br>revealed she was very satisfied with all aspects of<br>care and services received at the facility.<br><br>During an interview with the administrator on<br>..... at approximately 12:00 noon, she<br>acknowledged not having an order for the<br>resident to obtain her own ..... glucose levels<br>and self administer her ..... and further stated<br>that she would call the prescribing provider for the<br>order right away. If unable to obtain an order for<br>self administration (due to a history of .....<br>..... then she would obtain the order for<br>nursing visits daily to give the ..... injection and<br>clarification that facility trained med tech staff<br>could assist with the remainder of her medication<br>regime.<br><br>Class III<br>..... | A 050                                                                          |                                                                                                                          |                          |                               |
| A 052                                                      | 58A-5.0185(3) FAC Medication - Assistance with<br>Self-Admin<br><br>(3) ASSISTANCE WITH<br>SELF-ADMINISTRATION.<br>(a) For facilities which provide assistance with<br>self-administered medication, either: a nurse; or<br>an unlicensed staff member, who is at least .....<br>..... trained to assist with self-administered<br>medication in accordance with Rule 58A-5.0191,<br>F.A.C., and able to demonstrate to the<br>administrator the ability to accurately read and                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | A 052                                                                          |                                                                                                                          |                          |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                          |  |                               |
|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 052                                                      | Continued From page 3<br><br>interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.<br>(b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.<br>(c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.<br>(d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:<br>1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;<br>2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record;<br>3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or<br>4. Medications may be separately prescribed and | A 052                                                                          |                                                                                                                          |  |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                          |  |                               |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 052                                                      | <p>Continued From page 4</p> <p>dispensed in an easier to use form, such as unit dose packaging;</p> <p>(e) Pursuant to Section 429.256(4)(h), F.S., the term "competent resident" means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.</p> <p>(f) Pursuant to Section 429.256(4)(i), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition.</p> <p>(4) Assistance with self-administration does not include:</p> <p>(a) Mixing, _____, converting, or _____ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.</p> <p>(b) The preparation of syringes for injection or the administration of medications by any injectable route.</p> <p>(c) Administration of medications through intermittent positive pressure breathing machines or a _____.</p> <p>(d) Administration of medications by way of a tube inserted in a cavity of the body.</p> <p>(e) Administration of _____ preparations.</p> <p>(f) Irrigations or debriding agents used in the treatment of a skin condition.</p> <p>(g) _____ or _____ preparations.</p> <p>(h) Medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.</p> <p>(i) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the</p> | A 052                                                                          |                                                                                                                          |  |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                          |  |                               |
|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 052                                                      | <p>Continued From page 5</p> <p>reason for administration requires judgment or discretion on the part of the unlicensed person.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to assure 1 (Resident #1) of 5 residents whose medication orders were reviewed and reconciled- had the ordered medications available and/or had made documented efforts to obtain clarification of the orders, and by inaccurately documenting on the medication observation record (MOR), gave a false representation to the prescribing provider of what medications the resident was receiving thereby placing the resident at risk for complications.</p> <p>Findings include:</p> <p>Record review revealed Resident #1 had diagnoses including . . . . . Further review revealed orders for . . . . . 100mg plus 25mg to total 125mg orally every night. In order to fill an order for . . . . . per a phone call to the filling pharmacy on . . . . . the prescribing physician would need to order . . . . . work including (whit cell count and neutroffils) on a frequent basis prior to the order being filled.</p> <p>Further record review revealed the resident (admitted to the facility in 2002) had a documented history of non compliance in both getting the required labwork drawn as required and for refusing to be seen by the physician- she would simply refuse or leave the center and go to a friends home nearby until it was time to return to the facility. Unless the center called the facility to make them aware of the situation, they did not know the resident was not getting the labwork and</p> | A 052                                                                          |                                                                                                                          |  |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                          |  |                               |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 052                                                      | <p>Continued From page 6</p> <p>therefore not getting the prescribed daily _____ dose.</p> <p>Interview with the administrator on _____ at approximately 12:00noon revealed an acknowledgement that her med tech trained staff including herself had not reconciled the medications with the MORs but rather, they checked the labels on the multipack packages only and did not question the fact that there was no _____ available. This happened she thought because the prescribed medications came in multipack doses packages with a label placed on the inside for each prescribed medication (on the inside of each multipackage). Staff continued to document that they were giving _____ even though that type of medication (with potentially frequent changes based on lab results) came in its own separate pill package. Staff did not pick up on the fact the medication was not available until notified by the physician's office on the last day it was filled.</p> <p>Further interview with the administrator revealed there had been ongoing communication problems with the _____ provider since they no longer provide case management to the resident although they do provide the medication management for her. Since the 1st filled script was filled in _____ the resident has refused labs again and the medication has not been filled since then. Confirmation with the laboratory during the survey revealed the most recent labs were drawn on _____ the same day the order was written and the lab confirmed they faxed the results to the prescribing physician/ARNP the same date which they confirmed the office received. A telephone interview with the filling pharmacist during the survey revealed the _____ order would have needed to be changed-</p> | A 052                                                                          |                                                                                                                          |  |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |  |                               |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 052                                                      | Continued From page 7<br><br>titrated, rather than just starting at the 125mg<br>dose and that he had previously notified the<br>prescriber of this and felt they just didn't get it.<br><br>While it is the resident's right to refuse to be seen<br>or to take her prescribed medications, the facility<br>staff continued to document that they were giving<br>the _____ on a daily basis even when it was not<br>available. This _____ the prescribing provider<br>who requested to be faxed a copy of the _____<br>MORs to them. The _____ MOR documented<br>that facility staff were assisting with all prescribed<br>medications including _____ although it was last<br>filled _____.<br><br>Class III<br><br>_____                                                                                                                                                                                                                                     | A 052                                                                          |                                                                                                                          |  |                               |
| A 054                                                      | 58A-5.0185(5) FAC Medication - Records<br><br>(5) MEDICATION RECORDS.<br>(a) For residents who use a pill organizer<br>managed under subsection (2), the facility shall<br>keep either the original labeled medication<br>container; or a medication listing with the<br>prescription number, the name and address of<br>the issuing pharmacy, the health care provider's<br>name, the resident's name, the date dispensed,<br>the name and strength of the drug, and the<br>directions for use.<br>(b) The facility shall maintain a daily medication<br>observation record (MOR) for each resident who<br>receives assistance with self-administration of<br>medications or medication administration. A MOR<br>must include the name of the resident and any<br>known _____ the resident may have; the name<br>of the resident's health care provider, the health<br>care provider's telephone number; the name,<br>strength, and directions for use of each | A 054                                                                          |                                                                                                                          |  |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |  |                               |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 054                                                      | <p>Continued From page 8</p> <p>medication; and a chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. The MOR must be immediately updated each time the medication is offered or administered.</p> <p>(c) For medications which serve as chemical _____, the facility shall, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure the daily documentation of the medication observation records (MORs) were correct for 2 (Residents #1 and #2) of 5 sampled residents whose MORs were reviewed, which did cause _____ to the prescribing physician/ARNP when trying to determine exactly what specific medications Resident #1 was receiving on a daily basis and could cause _____ if Resident #3's MORs were reviewed.</p> <p>Findings include:</p> <p>Record review revealed Resident #1 had orders for the following medications that were not correctly documented on the MORs:<br/>_____ 125mg, by mouth daily. It was scheduled at 8:00pm on the _____ and _____ MORs. The _____ was blank. The handwritten MORs for _____ did not have _____ listed on it.</p> <p>Confirmation by the pharmacy by phone on _____ revealed they had no current order for the _____ for _____ (because the prescriber had not sent a requested titrated order- needed any time when a person started and stopped this medication. A non titrated order was written by</p> | A 054                                                                          |                                                                                                                          |  |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                          |  |                               |
|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 054                                                      | <p>Continued From page 9</p> <p>the prescriber on _____ for 100mg plus 25mg nightly).</p> <p>Interview with the administrator on ____/12 at approximately 12:00noon revealed an acknowledgement that her med tech trained staff including herself had not reconciled the medications with the MORs but rather, they checked the labels on the multipack packages only and did not question the fact that there was no _____ available. This happened she thought because the prescribed medications came in multipack doses packages with a label placed on the inside for each prescribed medication (on the inside of each multipackage). Staff continued to document that they were giving _____ even though that type of medication (with potentially frequent changes based on lab results) came in its own separate pill package. Staff did not recognize the fact the _____ was not available until notified by the physician's office on the last day it was filled. If the medication was not available, the facility should have documented as such on the MOR and/or clarified if the order was still current.</p> <p>Interview with the resident on _____ at aproximatley 1:00 p.m. revealed she received medication assistance at the facility but she was very suspicious of the surveyor and did not want to engage with any more conversation. She did tell the surveyor when asked that the reason she sometimes refused to see the doctor and have _____ drawn or get her monthly shot (including the day of the survey) was because she was scared.</p> <p>_____ DE 50mg/ml inject 1cc intermuscularly every 4 weeks (provided by _____ center) was documented in error as assisted with on a</p> | A 054                                                                          |                                                                                                                          |  |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                       |                                                                                                                          |                               |
|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b> |                                                                                                                          |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE      |
| A 054                                                      | <p>Continued From page 10</p> <p>daily basis by unlicensed facility staff daily in _____ and _____</p> <p>Interview with the administrator on _____ at approximately 12 noon revealed she had not realized the staff were incorrectly documenting that they were administering an injection on a daily basis. She further acknowledged that she had no licensed staff employed at the facility and that the prescribed _____ was delivered by the pharmacy to the facility where it would be picked up by the _____ case workers and taken to the _____ center where the injection would be given monthly (if not refused by the resident). She had no explanation as to why there was no documentation of any drugs received by the resident in _____ but believed this was during one of the resident's frequent hospitalizations.</p> <p>Review of Resident #2's 07, 08 09 and _____ MORs revealed the following documentation errors:</p> <p>100units/ml, give 90 units injection every night. Review of the MORs revealed had no documentation to indicate the resident gave her own _____ (self administered) injections each night. Documentation on the MORs looked as if unlicensed staff were giving the _____ themselves (although they were not licensed and not qualified to give injections).</p> <p>30mg, take 1 tab each night.</p> <p>Review of the handwritten addition of the order showed it was given beginning on _____ and _____ with no documentation to explain on the back of the MOR why it was not given on the 24, 25, 27, 28, 29 or 30th or if it was simply not documented after being given.</p> <p>Per a phone call to the pharmacist during the survey, the pharmacist told the surveyor the</p> | A 054                                                                                                 |                                                                                                                          |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                          |                          |                               |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                          | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |                          |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                               |
| A 054                                                      | <p>Continued From page 11</p> <p>Temazepam was d/c on _____ and in its place<br/>Tart 10mg tab were filled. The<br/>medication was on hand but was not added to the<br/>_____ MOR. Instead, the _____ continued<br/>to be documented as being given when the<br/>_____ replaced it. Observation of the<br/>medications on hand revealed no<br/>available but did have 2 _____ gone from a<br/>package dispensed on _____ which would be<br/>correct.</p> <p>_____ 1mg, give 1 tab three times daily.<br/>The package had a label noted see dose change.<br/>The _____ MOR did not have _____ listed<br/>on it although it was listed on the previous 2<br/>months. Observation of the medication on hand<br/>revealed the medication was available and had<br/>been filled on _____ with 5 pills gone from the<br/>package of 90 pills.</p> <p>The resident told the surveyor during interview on<br/>_____ at approximately 12:00noon that she<br/>had been diagnosed as _____ dependent<br/>since about 18 months old and had<br/>provided her own _____ injections as long as she<br/>could remember. She stated staff got the<br/>for her and that she herself put turned the flex<br/>pen to the correct number of units (90 units of<br/>_____ nightly). She also said she had recently<br/>had sleeping problems and had the order of<br/>Tamazepam changed to _____. She had only<br/>positive comments about the care and services<br/>received at the facility and said she received all<br/>medications as ordered in a timely way and had<br/>no medication concerns.</p> <p>Class III</p> <p>Pattern</p> | A 054                                                                          |                                                                                                                          |                          |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                       |                                                                                                                          |                               |
|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b> |                                                                                                                          |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE      |
| A 055                                                      | Continued From page 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | A 055                                                                                                 |                                                                                                                          |                               |
| A 055                                                      | <p>58A-5.0185(6) FAC Medication - Storage and Disposal</p> <p>(6) MEDICATION STORAGE AND DISPOSAL.</p> <p>(a) In order to accommodate the needs and preferences of residents and to encourage residents to remain as independent as possible, residents may keep their medications, both prescription and over-the-counter, in their possession both on or off the facility premises; or in their ..... or apartments, which must be kept locked when residents are absent, unless the medication is in a secure place within the ..... or apartments or in some other secure place which is out of sight of other residents. However, both prescription and over-the-counter medications for residents shall be centrally stored if:</p> <ol style="list-style-type: none"> <li>1. The facility administers the medication;</li> <li>2. The resident requests central storage. The facility shall maintain a list of all medications being stored pursuant to such a request;</li> <li>3. The medication is determined and documented by the health care provider to be hazardous if kept in the personal possession of the person for whom it is prescribed;</li> <li>4. The resident fails to maintain the medication in a safe manner as described in this paragraph;</li> <li>5. The facility determines that because of physical arrangements and the conditions or habits of residents, the personal possession of medication by a resident poses a safety hazard to other residents; or</li> <li>6. The facility's rules and regulations require central storage of medication and that policy has been provided to the resident prior to admission as required under Rule 58A-5.0181, F.A.C.</li> </ol> <p>(b) Centrally stored medications must be:</p> <ol style="list-style-type: none"> <li>1. Kept in a locked cabinet, locked cart, or other locked storage receptacle, ..... , or area at all</li> </ol> | A 055                                                                                                 |                                                                                                                          |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |                                                                                                                          |                          |                               |
|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                          | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |                          |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                               |
| A 055                                                      | Continued From page 13<br><br>times;<br>2. Located in an area free of dampness and abnormal temperature, except that a medication requiring refrigeration shall be refrigerated. Refrigerated medications shall be secured by being kept in a locked container within the refrigerator, by keeping the refrigerator locked, or by keeping the area in which refrigerator is located locked;<br>3. Accessible to staff responsible for filling pill-organizers, assisting with self-administration, or administering medication. Such staff must have ready access to keys to the medication storage areas at all times; and<br>4. Kept separately from the medications of other residents and properly closed or sealed.<br>(c) Medication which has been discontinued but which has not expired shall be returned to the resident or the resident ' s representative, as appropriate, or may be centrally stored by the facility for future resident use by the resident at the resident ' s request. If centrally stored by the facility, it shall be stored separately from medication in current use, and the area in which it is stored shall be marked " discontinued medication. " Such medication may be reused if re-prescribed by the resident ' s health care provider.<br>(d) When a resident ' s stay in the facility has ended, the administrator shall return all medications to the resident, the resident ' s family, or the resident ' s guardian unless otherwise prohibited by law. If, after notification and waiting at least 15 days, the resident ' s medications are still at the facility, the medications shall be considered abandoned and may be disposed of in accordance with paragraph (e).<br>(e) Medications which have been abandoned or which have expired must be disposed of within 30 | A 055                                                                          |                                                                                                                          |                          |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                       |                                                                                                                          |                               |
|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b>                        | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b> |                                                                                                                          |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                                   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE      |
| A 055                                                      | <p>Continued From page 14</p> <p>days of being determined abandoned or expired and disposition shall be documented in the resident ' s record. The medication may be taken to a pharmacist for disposal or may be destroyed by the administrator or designee with one witness.</p> <p>(f) Facilities that hold a Special-ALF permit issued by the Board of Pharmacy may return dispensed medicinal drugs to the dispensing pharmacy pursuant to Rule 64B16-28.870, F.A.C.</p> <p>This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure discontinued or expired medications were disposed of within 30 days of identification for 2 (Residents #1 and #2) of 5 sampled residents whose medications were reconciled and by not removing them from the residents medication area placed the residents at risk of receiving expired or discontinued medications that could result in ineffective results.</p> <p>Findings include:</p> <p>Review of Resident #1's medication orders and observation of her available medications revealed the following expired medications contained in a plastic bag labeled with the resident's labeled name dated .....</p> <p>* ..... discus 250mcg/salmeterol 50mg container with no opened date. The expiration date on the back of the case was .....</p> <p>*A hand held inhaler, Proair was dated (also expired)</p> <p>..... a tube unlabeled of</p> <p>Review and observation of Resident #2's medication orders and observation of the resident's available medications revealed the following ..... that may have been expired but</p> | A 055                                                                                                 |                                                                                                                          |                               |

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                          |  |                               |
|------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964399</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GEORGIA'S PLACE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2101 7TH STREET, SOUTH<br/>SAINT PETERSBURG, FL 33705</b>                    |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE      |
| A 055                                                      | <p>Continued From page 15</p> <p>remained available for use:<br/>           _____ 100units/ml. There were no<br/>           opened dates for 2 of the _____ flex pens<br/>           although both of them had been opened. The<br/>           _____ instruction insert read it was good for 42<br/>           days after opening. It could not be determined if<br/>           the _____ was expired since they were not<br/>           labeled, but there were 2 additional unopened<br/>           labeled _____ flexpens observed that<br/>           were available for the resident's use.</p> <p>Interview with the administrator during the survey<br/>           on _____ at approximately 1:30 p.m. revealed<br/>           she was unsure why the expired medications<br/>           were in a baggy in the resident's medication<br/>           drawer and additionally said the resident was not<br/>           receiving any of them. She said it was an<br/>           oversight to not have the opened date on the<br/>           _____. The caregiver/med tech on duty also<br/>           could not explain why the expired meds were in<br/>           the resident's medication drawer and also said<br/>           she was not receiving them.</p> <p>Class III</p> <p>_____</p> | A 055                                                                          |                                                                                                                          |  |                               |



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

2012

Administrator  
Georgia's Place  
2101 7th Street, South  
Saint Petersburg, FL 33705

Dear Administrator:

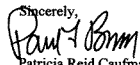
Re: CCR# 20120010308

This letter reports the findings of a complaint survey that was conducted on 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,  
  
For Patricia Reid Cauffman  
Field Office Manager

PRC/kpr

Enclosure: State Form 3020

