Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11967286	A. BUILDING: _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOVING CARE OF ST PETERSBURG	1001 9TH STREET NORTH SAINT PETERSBURG, FL 33701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Facility Two complaint surveys, CCR# 2013003268 & CCR# 2013003293 were conducted on . The Loving Care of St. Petersburg, assisted living facility, had deficiencies found at the time of the visit.	A 000		
A 025	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents,	A 025		

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A 025	Continued From page 1	A 025		

changes in the method of medication administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on record review and staff and family interview, the facility failed to have awareness of the general health, safety, and physical and emotional well being for 1 out of 3 sampled residents (#1).

Findings include:

A record review of Resident #1's medical record revealed the resident was admitted on . The medical diagnosis for the resident was and .

Resident#1's family was visiting on and left early in the afternoon. Resident #1 was last seen when he took his medication during the evening medication pass at 8:00 p.m.. The resident's mother stated during the telephone interview on at 11:51 a.m. that the next day, , she tried to contact him on the cellular phone but he did not answer. She tried again the next day, , and still no answer. She finally called the facility and spoke with the 3p to 11p Staff #E. Staff #E stated she had not seen the resident but she would call the administrator to see if he knew the location of the resident. The administrator said he did not know where the resident was and he wanted her to start searching the facility and call the hospitals. The mother also asked that she fill out a missing persons report. The search of the facility did not find the resident. The hospitals did not have the resident. The missing person report was filed and the police said they would come over later that

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A 025	Continued From page 2 night. Staff #C stated on at 12:30 a.m.that on he had just started working his 11p-7a shift, when the police came and told me that Resident #1 had on Monday, at around 7:00a.m. "I did not know what to say because I did not even know he was gone". I did call Resident #1's mother and told her about what had happened to her son. Resident #1's , Resident #4, was interviewed at 1:45p.m., Resident #4 stated when he got up around 6:00 a.m. or 6:30 a.m. on and Resident #1 was not in his bed. "He was always in his bed unless his mother came to visit him. I did not know where he was." Interviewed 7a-3p staff # F by phone on at 2:00 p.m. This was her day off but she had worked the 7a-3p shift on both and . She stated Resident #1 did not come to the nurse ' s station to get his morning medication on . She waited for a little while then went to his he was not there. She asked Resident #4 where Resident #1 was and he said he did not know. She said this was unusual because Resident #1 was always in his . She went back and put " absent " into the electronic medication observation record (MOR). She did not tell anyone that Resident #1 did not get his medication. When the 3p.m.-11p.m. Staff #D for was interviewed on at 11:30 p.m.she stated Resident #1 did not come for his evening medication so she went looking for him. She could not find him and she just assumed he was out with his mother so she put " absent " in the MOR for his medication. Staff #C said she probably should have asked some of the staff	A 025		

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A 025	Continued From page 3	A 025		

where he was but she was very busy with medication and housekeeping and never got the chance to ask around.

The next day, Resident #1 was not there for his morning medication so Staff #F looked around for him but did not find him so she put " absent " in the MOR again. She said she should have called the hospitals and told someone he was not there but she was so busy being the only Med Tech passing medications that she just forgot to tell anyone.

When interviewed on at 2:30p.m., Staff #E said she worked the 3p-11a shift on . Resident #1 did not come down for the evening medication so she went looking for him. He was not anywhere to be found which is unusual because he was always in bed unless he was out with his mother. She put " absent " in the MOR. Later that night, Resident #1's mother called and asked about her son because she had not been able to contact him. I told her I had not seen him either but I would call the administrator and see if he knew where the resident was. I called the administrator around 9:30 p.m. and he said he did not know where he was so she should start looking for him. I told this to Resident #1's mother and I hung up so I could start looking. I called the hospitals and looked all over the property. The mother called back and asked if we could file a missing person report because she was told by the police that if the facility filed the report, they could come out the same day. "A missing person report was turned in by me and the police said they would be late coming out because they were very busy. They came after I left but they told Staff #C what had happened to Resident #1."

The facility did not know for two days the general

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A 025	Continued From page 4 whereabouts of Resident #1. The staff did not notify anyone that the resident had not been seen and he had not taken his medication in two days. The staff did not notify the administrator of Resident #1's absence and elopement measures were not implemented until the mother called and asked about the whereabouts of her son. Class III	A 025		
A 163	429.49 FS Records - Resident, Penalties for Alteration Resident records; penalties for alteration.- (1) Any person who fraudulently alters, defaces, or falsifies any medical or other record of an assisted living facility, or causes or procures any such offense to be committed, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. (2) A conviction under subsection (1) is also grounds for restriction, suspension, or termination of license privileges. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility altered the medication observation record (MOR) for 1 (#1) of 3 sampled residents. The record was altered despite the fact that the facility had no knowledge of resident #1's whereabouts for 2 days, after resident #1 was hit and fatally injured by an automobile while outside of the facility. Findings include: On the early morning of , resident #1 suffered fatal injuries from a pedestrian vs. motor vehicle accident. On , while at the facility,	A 163		

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A 163	Continued From page 5	A 163		

for a complaint survey the administrator provided a facility form that showed that the resident signed out 4 days worth of his medication from the facility on the morning of . According to the administrator the resident informed the 11pm - 7am med tech (Confidential Informant #1) (CI) that he was going out of town to visit family. The form had the printed name of the resident and a signature matching the name of the resident. It also listed confidential informant #1's name as a witness. According to the Administrator, he did not know what time the resident signed out his medications. He did state that it had to be before 7:00 a.m., since the CI#1's shift ended at 7:00am.

On , a review of Resident #1's 2013 MORs was conducted. According to the electronic MOR on the AM medication pass on , CI#2 initials are on it indicating that resident #1 was "signed out" of the facility. The PM medication pass on , CI#4 initials are on the MOR with the same indication that the resident is "signed out."

On the AM medication pass for , CI#2 initials are on it indicating that the resident #1 was "signed out." On the PM medication pass CI#3 initials are on the MOR indicating that the resident was still signed out.

On , at approximately 12:15 a.m., a telephone interview was conducted with CI#1. At that time he stated that the administrator spoke with him on (exact time unknown) and said "the facility has messed up." He then had CI#1 fill out the form indicating that resident #1 signed out his medications on . He stated at first he went along with this but was uncomfortable doing this. He stated he wanted to

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A 163	Continued From page 6	A 163		

tell the truth now and that resident #1 did not sign out his medications on . He stated that the administrator filled out the form and placed CI#1's name on it.

On , at 2:00 p.m. a telephone interview with CI#2, conducted. According to CI#2, she marked Resident #1's 2013 electronic MORs for the 18th and 19th as him being absent for his morning medication pass. When informed that the dates indicated on the 2013 MOR that she marked him as "signed out" on the 18th and 19th she denied placing that mark on the MOR.

On , at 2:30 p.m. an interview was conducted with CI#3. She stated that on resident's # MOR for the date of 19th evening medication pass she marked him as being absent. When informed that the MOR indicated that she marked him being signed out she denied checking that box. When asked if any of the med techs have the administrative rights to go into the computer system and change the MORs CI#2 stated no and only staff that she knew of that could do this would be someone in the administration.

On at 11:30 p.m. a telephone interview was conducted with CI#4. She stated that for the evening medication pass conducted , she marked resident #1 was being absent. When informed that according to the 2013 MOR she marked him as being signed out, she denied checking that box.

Class II

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Loving Care of St Petersburg
1001 9th Street North
Saint Petersburg, FL 33701

Dear Administrator:

Re: **CCR# 2013003268 & CCR# 2013003293**

This letter reports the findings of two complaint surveys that were conducted on , 2013, by representatives 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 surveyors. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

Patricia Reid Caufman
For Field Office Manager

PRC/kpr

Enclosure: State Form 3020

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