STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964399	07/31/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Georgia's Place	2101 7th Street, South Saint Petersburg, FL 33705	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0010 - 58a-5.0181(4) Fac - Admissions - Continued Residency S-S= J
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= J
St - A - 0080 - 58a-5.0191(1) Fac - Training - Core & Competency Test S-S= D
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D
St - A - L243 - 58a-5.0191(8) Fac - Lmh - Training S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

An unannounced complaint survey, CCR# 2013007848, was conducted on .

Georgia's Place, assisted living facility, had deficiencies at the time of the visit.

0010-Admissions - Continued Residency 58A-5.0181(4) FAC

Based on interviews and record reviews, the facility failed to discharge a resident who was exhibiting inappropriate behavior toward another resident, which ultimately led to a assault, and was no longer appropriate for continued residency for 1 (Resident #4) of 4 residents sampled for record review.

Findings include:

A review of Resident #4's record revealed that he was readmitted to the facility on . He had previously been a resident at the facility between and . He was diagnosed with a history of on his health assessment, Form 1823 dated . The history and physical of a hospital admission dated reported that Resident #4 had a history of legal charges of breaking and entering and armed robbery, and other crimes, and had served prison time of 9 years total.

An interview with Resident #3 on at approximately 2:00 p.m. revealed that the resident reported being threatened by a knife and assaulted by Resident #4 on in the the facility's enclosed, back porch.

An interview with law enforcement on at approximately 11:30 a.m. revealed that Resident #4 had been on for battery and was still in custody.

An interview on with Staff A on at approximately 12:10 p.m. revealed that Resident #3 had reported to facility staff that Resident #4 made explicit comments to her by a text message sent to her phone a couple of months ago. Resident #3 also told staff that Resident #4 asked her to touch him at a public bus stop. Staff A stated that staff told Resident #3 to stay away from Resident #4 and to never be alone with him.

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A further interview with Staff A on [redacted] at approximately 12:10 p.m. revealed that after Resident #3 reported she had been [redacted] assaulted, Staff A did not confront Resident #4 because she was scared because he threatened his sister the day before. Staff A stated that Resident #4 said, "his sister didn't know who she was messing with and was lucky she's not [redacted] and he didn't have one of his friends put a bullet in her." Staff A stated she told the administrator what the resident had said and the administrator told her to call his sister and let her know what he was saying. Staff A told Resident #4's sister and she stated that Resident #4 had threatened that before, but had not acted on it. Staff A reported that Resident #4 had also been verbally [redacted] to other residents.

In the interview with the administrator on [redacted] at approximately 4:00 p.m., she stated that Resident #4 had made advances to Resident #3 during Resident #4's first time at the facility and staff told her to stay away from him, but Resident #4 continued to buy her sodas and food and cigarettes. The administrator reported that she was told by Resident #3 that Resident #4 had sent her text messages with [redacted] content when he was readmitted to the facility around [redacted]. The administrator stated Resident #3 also told her about 3 weeks ago that Resident #4 asked her to fondle him when they were going to a restaurant. The administrator stated that she told Resident #3 to stop spending time with Resident #4, giving him double messages.

An interview with Staff B on [redacted] at approximately 8:00 p.m. revealed that she had also been told by Resident #3 that she had been sent a text message by Resident #4 that stated what he wanted to do to her [redacted] Staff B stated that the staff told Resident #3 to stop sitting around him and detach herself because she may be giving him the wrong impression.

Review of Resident #3's progress notes dated [redacted] reported that the resident had told the administrator several months ago about the text messages with [redacted] comments that Resident #4 had sent Resident #3. Resident #3 was encouraged to stay away from Resident #4, for they had been spending time together. There were no other notes from [redacted] to [redacted] that addressed any of the [redacted] advances made by Resident #4.

Review of Resident #4's progress notes dated from [redacted] to [redacted] did not reveal any notes that mentioned problem behaviors or reports of [redacted] advances to another resident.

Review of Resident #4's resident contract which was signed by the resident on [redacted] indicated reasons for discharge. On page 2 of the contract, under the heading " Criteria that would require the resident to leave the facility, " number 2 states, " If the resident's behavior becomes disruptive or disturbing to the extent that it interferes with the well-being of the other residents, such as keeping other residents awake at night, not respecting the rights and property of other residents, being verbally or physically [redacted] to other residents."

The staff reported that they were aware of Resident #4's [redacted] advances, both verbal and by text messages to Resident #3 prior to the [redacted] assault. Facility staff just told Resident #3 to stay away from Resident #4 and never be alone with him.
There were no reports in the staff interviews or the residents' records about direct actions taken to resolve the concerns regarding Resident #4's reported [redacted] advances toward Resident #3. Resident #4's behavior was still not deemed "disruptive or disturbing", even though Staff A stated she was scared to confront him because he had left life threatening messages for his sister the day before the [redacted] assault and was verbally [redacted] to other residents.

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Further review of Resident #4's record revealed that he was not given a notice to leave the facility even though his reported behavior met the criteria for discharge written in the facility's contract.

Class I

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on interviews and record reviews, the facility failed to ensure a resident's right to live in a safe living environment, free from for 1 (Resident #3) of 4 residents sampled for record review.

Findings include:

A review of Resident #3's record revealed that she was admitted to the facility on as a limited mental health resident. Her health assessment, Form 1823 dated listed her diagnoses as impulse control and history of

A review of Resident #4's record revealed that he was a resident at the facility the first time between and He was readmitted to the facility on His health assessment, Form 1823 dated listed a history of for a diagnosis. The history and physical of a hospital admission dated reported that Resident #4 had a history of legal charges of breaking and entering and armed robbery, and other crimes and had served prison time of 9 years total.

Interviews conducted on with Staff A at approximately 12:10 p.m. and Resident #3 at approximately 2:00 p.m. revealed that Resident #3 reported that she was assaulted on by Resident #4 in the the facility's enclosed, back porch. Resident #4 was by law enforcement and removed from the facility. Resident #3 reported to Staff A that she had wanted to hurt herself directly after the assault.

An interview with law enforcement on at approximately 11:30 a.m. revealed that Resident #4 had been on for battery and was still in custody.

An interview with Staff A on at approximately 12:10 p.m. revealed that Resident #3 reported to facility staff that Resident #4 made explicit comments to her by a text message sent to her phone a couple of months ago. Resident #3 also told staff that Resident #4 asked her to touch him at a public bus stop. Staff A stated that staff told Resident #3 to stay away from Resident #4 and to never be alone with him. Staff A also reported that after Resident #3 reported she had been assaulted that she did not confront Resident #4 because she was scared because he threatened his sister the day before. Staff A stated that Resident #4 said, "his sister didn't know who she was messing with and was lucky she's not and he didn't have one of his friends put a bullet in her." Staff A stated she told the administrator what the resident had said and the administrator told her to call his sister and let her know what he was saying. Staff A told Resident #4's sister and she stated that Resident #4 had threatened that before, but had not acted on it. Staff A reported that Resident #4 had also been verbally to other residents.

An interview with Resident #3 on at approximately 2:00 p.m. revealed that she had went to a restaurant with Resident #4 about a month ago. At the bus stop, Resident #4 asked Resident #3 to touch him in a manner. She stated that Resident #4 apologized and told her he would not do it again. She stated she did not go out with him to a restaurant again. Resident #3 also stated that Resident #4 sent her a couple of text messages to her phone a couple of weeks ago which were "nasty messages" about what he wanted to do to her

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Resident #3 stated that she reported these incidents to the facility staff and they told her to stay away from him and don't be by herself with Resident #4. After explaining that she had been threatened with a knife and then assaulted on . . . . . by Resident #4, she stated that she had "told staff the week before that and the week before that, all the nasty things Resident #4 stated to her." Facility staff still told her to stay away from him and never be alone with him.

An interview with the administrator on . . . . . at approximately 4:00pm revealed that Resident #4 had made advances to Resident #3 during Resident #4's first time at the facility and staff told her to stay away from him, but Resident #4 continued to buy her sodas and food and cigarettes. The administrator reported that she was told by Resident #3 that Resident #4 had sent her text messages with . . . . . content when he first was readmitted to the facility around . . . . . The administrator stated Resident #3 also told her about 3 weeks ago that Resident #4 told her to fondle him when they were going to a restaurant. The administrator stated that she told Resident #3 to stop spending time with Resident #4, giving him double messages. The administrator stated that she didn't know what roll Resident #3 played in going into that . . . . . Resident #4. There were other residents on the back porch when this happened and staff was in there and Resident #3 did not call anyone for help.

An interview with Staff B on . . . . . at approximately 8:00 p.m. revealed that she had been told by Resident #3 that she had been sent a text message from Resident #4 in which he stated what he wanted to do to her . . . . . Staff B stated that the staff told Resident #3 to stop sitting around him and detach herself because she may be giving him the wrong impression. Staff B stated that Resident #3 placed herself in this predicament because they told her to detach herself from him.

A review of Resident #3's progress notes dated from . . . . . to . . . . . revealed no notes about her telling staff about Resident #4's . . . . . explicit phone texts until after the assault on . . . . . Resident #3's progress notes dated . . . . . 13 addressed the . . . . . assault and reported that the resident had told the administrator several months ago about the text messages with . . . . . comments that Resident #4 had sent Resident #3. Resident #3 was encouraged to stay away from Resident #4, for they had been spending time together.

A review of Resident #4's progress notes dated from . . . . . to . . . . . reflected staff's observations of the resident; however, there was no mention of any problem behaviors or reports of . . . . . advances (in person or by text) from the resident to Resident #3.

The facility staff reported that they were aware of Resident #4's . . . . . advances, both verbal and by text messages to Resident #3. Facility staff's only response was to instruct Resident #3 to stay away from Resident #4 and never be alone with him.
There were no reports in the staff interviews or the residents' records about direct actions taken to resolve the concerns regarding Resident #4's reported . . . . . advances toward Resident #3. This lack of action by facility staff impinged upon Resident #3's right to live in a safe living environment, free of . . . . . Resident #4 was . . . . . for . . . . . battery on Resident #3 on . . . . .

In the interview with the administrator on . . . . . at approximately 5:00 p.m., she acknowledged that Resident #3 may not have been feeling safe in the situation.

Class I

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0080-Training - Core & Competency Test 58A-5.0191(1) FAC
Based on record review and interviews, the facility failed to ensure that the administrator completed the required 12 hours of continuing education in assisted living topics every 2 years for 1 of 1 administrators in the facility.

Findings include:

A review of the administrator's employee record revealed that she only completed 4 contact hours for the assistance with self-administration of medications on [redacted]. There was no documentation of any other completed continuing education in her employee record for the past 2 years.

In the interview with the administrator on [redacted] at approximately 5:45 p.m., she acknowledged that she could not find any other training in her record.

In the phone interview with the administrator on [redacted] at approximately 4:35 p.m., she stated that she did not believe she completed 12 hours of continuing education in the past 2 years.

Class III

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on observation, record review and interview, the facility failed to make a required report of [redacted] of a resident to a state program for 1 (Resident #3) of 4 residents sampled for record review.

Findings include:

A review of Resident #3's record revealed there was no documentation that the facility had made a required report of the resident's [redacted] assault by another resident to a state program.

An interview with the administrator on [redacted] at approximately 4:00 p.m. revealed that she had not reported the [redacted] to the necessary state program. She stated that she was not aware that she had to make a report.

Observation of the administrator during the survey on [redacted] at approximately 5:30 p.m. revealed that she called and reported the [redacted] to the necessary stated program.

Class III

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L243-LMH - Training 58A-5.0191(8) FAC
Based on record review and interviews, the facility failed to ensure that all direct care staff that worked with limited mental health residents completed the required 3 hours of continuing education biennially in mental health topics for 2 (the administrator and Staff A) of 3 sampled employees.

Findings include:

A review of the administrator's employee record revealed that she had completed the required 6 hours of initial mental health training on .....
Review of Staff A's employee record revealed that she had completed the required 6 hours of initial mental health training on .....
Further review of the administrator's and Staff A's employee records revealed that there was no documentation of completion of any continuing education in mental health topics in greater than 2 years.
Interview with the administrator on ..... at approximately 6:00 p.m., she acknowledged that they had not had any continuing education in mental health topics in the past 2 years.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2013

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

Dear Administrator:

Re: **CCR# 2013007848**

This letter reports the findings of a complaint survey that was conducted on . 2013, by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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

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

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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