STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968024	10/14/2013
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Bristol Court Assisted Living	**3479 54th Ave N Saint Petersburg, FL 33714**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

Two unannounced complaint surveys, CCR# 2013008369 and CCR# 2013009503 were conducted in conjunction with a limited nursing services (LNS) survey on .

The Bristol Court Assisted Living Facility had deficiencies at the time of the visit.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

Based on record reviews and interviews, the facility failed to document change in condition and notification to the resident's doctor and their responsible party, specifically regarding the need for . care and weight loss and any interventions ordered for 3 (Residents #2, #3, and #4) of 4 residents sampled for record review.

Findings include:

In the interview with the assistant administrator (AA) on . at approximately 5:10pm, he stated that he tried to reach Resident #2 ' s daughter 3 times to inform her that her father had been sent to the hospital for hip pain. However, review of Resident #2 ' s Notes in his computerized record revealed that on . the resident ' s daughter was notified that resident had been sent to the hospital with complaints of hip pain. The note also reported that the resident was sent to the hospital on ; therefore, she was notified 2 days after his hospitalization. There was no record that the resident ' s daughter had been notified before this time frame.
Phone interview with Resident #2 ' s daughter on . at approximately 3:40pm revealed that she had been notified by the hospital Labor Day weekend (2013) that her father was admitted to the hospital with a hip . She reported that the facility staff did not contact her until 4 days after he was in the hospital.
Review of the facility's weight report revealed that Resident #2's weight decreased from 186 pounds in . to 154 pounds in . He lost a total of 32 pounds in less than 5 months. His Notes in his computerized record dated from his admit date . to after he left the facility . did not address his weight loss. There was also no notification to his doctor in his record about his weight loss or any interventions for the weight loss.
Review of a facility report for Resident #3, dated , revealed that the resident reported that he became . and almost . in the , but caught himself. He came to the nurses ' station with a laceration on his . The report indicated that he refused transport to the emergency . applied his own bandage with assistance. The resident's computerized Notes (resident observation or progress notes) revealed no report of this incident in the resident's record. There were no Notes for .
In the interview with Resident #3 about the incident on . at approximately 2:00pm, he stated that he stumbled in the . into the door. The is getting better and the nurse comes 2 times a week. She is a good nurse from home health.

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The facility's weight report indicated that Resident #3 lost 14 pounds from [redacted] to 06/2013. There were no Notes in his record about the weight loss or notifications to his doctor.
In the interview with the assistant administrator on [redacted] at approximately 4:50pm, he stated that the residents' weights are faxed to the residents' doctor's office every month, but did acknowledge that there was no documentation of this.
Review of Resident #4's home health notes dated [redacted] indicated that the resident was seen for [redacted] care for his left upper, inner thigh. There were no Notes in his record about this [redacted] at all. The last Notes were dated [redacted].

Class III

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

Based on record reviews and interviews, the facility failed to ensure that a resident was provided appropriate health care in a timely manner for 1 (Resident #2) of 4 residents sampled for record review.

Findings include:

Review of Resident #2's record revealed that there was only one entry in the resident's computerized Notes about the resident's hospital admission. The notes dated [redacted] stated that the resident was sent to the hospital on [redacted] via ambulance for complaint of hip pain. Resident stated he did not [redacted] and no one witnessed a [redacted]. Interview with Staff H, a resident assistant on [redacted]/13 at approximately 4:40pm revealed that on [redacted] Resident #2 had been seen walking earlier during the shift. She went to change his disposable brief at about 10pm. She noticed that his leg was up in bed (his foot was down on the bed, but his knee was up). She asked him to relax his leg, but he wouldn't. He told her he was in pain. He tried to stand up, but he flopped back down in bed. He stated he was in pain. When she asked if he had [redacted], he stated, "no." She called or texted the assistant administrator (AA), and reported that Resident #2 was in bed and he was aggressive because his leg hurt and they were trying to change him. She did not get a response back. She stated she also told the 11pm to 7am shift about Resident #3. When she came back to work 2 days later, he was gone.
Interview with the AA on [redacted] at approximately 5:10pm revealed that he received a call during the 3pm to 11pm shift telling him that Resident #2 complained of pain. The AA came to the facility at 5:30am (the next morning). He came to assess Resident #2. He stated the resident was just saying "ouch" and grimacing. He was not stating anything specific. The resident stated "no," when asked if he [redacted]. The AA asked all the staff on those shifts if Resident #2 had [redacted] and they said, "no." Resident #2 went to the hospital by ambulance during the 7am to 3pm shift. The resident's physician was notified that the resident was being sent out, during the process of sending him out. The AA stated he tried to notify the resident's daughter because she is the responsible party and he wanted to let her know the resident was going out to the hospital. He tried to reach her 3 times. The hospital staff finally reached the daughter. The resident is currently in rehab and the daughter wants him to come back to the facility, according to the assistant administrator.
Phone interview with Resident #2's daughter on [redacted] at approximately 3:40pm revealed that she had received a call from the hospital emergency [redacted] her that her father had been admitted. She stated the nurse told her that they believed this was a medical neglect case. Emergency medical services told the staff that the facility staff reported that the resident had lain in the bed at the facility for 2 days. The daughter was also told that there was no way that the resident could have got into bed by himself due to his condition. He had dislocated and [redacted] his hip. He was [redacted] and [redacted]. He had to be stabilized before he could even have surgery. She went to the hospital right away. She stated that the facility didn't try to get in touch with her until 4

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days after he was in the hospital. She received a call from Staff J, the former director of nursing (DON) because Staff J tried to get an update from hospital and they were told they couldn't get any information because of privacy laws. She stated that Staff J acted like nothing was wrong until she found out that his daughter had been at the hospital with her father. Resident #2's daughter received an for not being notified about her father. She stated she spoke to the AA a few hours later. The facility was notified by her that her father was in surgery. She stated that the AA and the administrator tried to call her several times after that but she refused to answer their calls. She told the staff that he would no longer be a resident and would not be coming back. She picked up his belongings.

Phone interview with Staff J about Resident #2 on at approximately 9:30pm revealed that she and the AA worked alternate weekends at the facility. She was off that weekend and the AA was working. She stated staff would send her text messages even when she was off because it bothered her that a resident might be sent to the hospital over the weekend and she wouldn ' t know what happened when she came back on Monday. Staff F, the resident care assistant supervisor who works the 7am to 3pm shift sent her a text message that Resident #2 had hip pain. He had been given the pain medication he had prescribed (believed it was or Staff J told Staff F to send him out to the hospital. Staff Fcalled the ambulance to pick him up around 7:30am. Staff J stated she had called the daughter a couple of days later to find out what was wrong with the resident. His daughter stated he was in surgery. His daughter was upset because she stated she never received a phone call from the facility about Resident #2's She was called by the hospital. Staff J stated that the AA should have told her. His daughter expressed her displeasure. The daughter stated her father was and could not have surgery for a couple of days until he was . She talked to the daughter for about 20 minutes and the daughter stated she was going to look into what happened because she was kept in the dark about her father and did not know if other things had happened to him. Staff J suggested to the AA and the administrator that they call to explain what happened because the daughter was upset. She left a message in their account (computerized system). They tried to call the daughter, but got no answer.

The daughter was notified by cell phone on and stated the resident was in the operating surgery on his right hip.

Interview with Staff G on at approximately 2:15pm revealed that if a resident complained of pain or other illness, she would call the assistant administrator and tell him what was going on with the resident. He would tell her what to do from there.

Interview with the AA on at approximately 4:50pm revealed that if a resident had an illness or change in condition the staff would notify the supervisor and she would notify him. He would then contact the doctor or home health whether it was day or night.

Resident #2 had complained of pain and would not move his leg because of the pain at approximately 10pm on , but the AA failed to come to the facility or call to determine the severity of the resident's situation until the next morning. The resident's doctor and home health were not called to evaluate or assess the resident. The resident's medical care was delayed for hours while waiting for the AA.

Class II

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2013

Administrator
Bristol Court Assisted Living
3479 54th Ave N
Saint Petersburg, FL 33714

Dear Administrator:

Re: **CCR# 2013008369** & **CCR# 2013009503** & LNS Monitoring Visit

This letter reports the findings of two complaint surveys and a limited nursing services (LNS) monitoring visit that were conducted on , 2013, by representative(s) of this office.

Attached are the provider's copies of the State (5000-3547) Forms, which indicate 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 surveys.

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(s). Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: State (5000-3547) Forms

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Bristol Court Assisted Living
3479 54th Ave N
Saint Petersburg, FL 33714

Dear Administrator:

This letter reports the findings of a complaint survey, CCR# 2013008369 and CCR# 2013009503, conducted on , 2013, by representatives of the Agency for Health Care Administration (Agency). Attached is the provider's copy of the Statement of Deficiencies, which indicates there were deficiencies noted during the inspection. You are hereby responsible for complying with the Agency's Directed Plan of Correction (DPOC) within **five business days** of receipt of this mailed report.

The inspection resulted in findings of non-compliance in the following areas:

St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= G

Directed Corrective Actions:

1. The Assisted Living Facilty is required to establish a written policy as to how resident's family member/guardian is notified in the event the resident has a change in condition or is transferred to a higher level of care. Policy must ensure that attempts to reach Family Member/Guardian are documented in the resident's chart.

2. The Assisted Living Facilty is required to establish a policy to ensure that residents who experience a change in condition evidenced by such things as increased pain, unresponsiveness, altered mental state or residents who experience a ..... are assessed in a timely manner and such assessment and outcome is documented in the resident's chart.

3. The Assisted Living Facilty is required to provide training on above policies to all direct care staff.

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St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161

Please be advised that nothing in this DPOC limits the Agency's authority and responsibility to impose administrative sanctions as provided by law.

Should you have any questions, please call ..... **Catherine Anne Avery**, Survey and Certification Support Branch, at (850) 412-4505.

Sincerely,

Paul J Bonn

Patricia Reid Caufman
Field Office Manager

PRC/kpr

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