STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967604	03/14/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Good Hope Of Pinellas	7575 65th Way Pinellas Park, FL 33781	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:

St - A - 0008 - 58a-5.0181(2) Fac - Admissions - Health Assessment S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0091 - 58a-5.0191(12) Fac - Training - Documentation & Monitoring S-S= B
St - A - 0163 - 429.49 Fs - Records - Resident, Penalties For Alteration S-S= G
St - A - 0165 - 429.23 Fs; 58a-5.0241 Fac - Risk Mgmt & Qa; Adverse Incident Report S-S= D

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

Two complaint surveys, CCR# 2014001850 and CCR# 2014002130, was conducted from

The Good Hope of Pinellas, assisted living facility, had deficiencies at the time of the visit.

0008-Admissions - Health Assessment 58A-5.0181(2) FAC

Based on interview and record review, the facility failed to obtain complete documentation of a face-to-face health assessment from a medical provider (AHCA form 1823) for 3 of 11 sampled residents (Resident #1, Resident #2 and Resident #3).

Findings include:

During a review of the record for Resident #1 conducted during an investigation at the facility on the record revealed an 1823 form dated Page 4 of the form indicated Resident #1 needed assistance with medication but did not indicate what type or level of assistance was needed.

A review of the record for Resident #2 on the same date revealed that Resident #2 was admitted on and had an 1823 form signed by a medical provider also dated However, the 1823 form was blank other than the signature.

A review of the record for Resident #3 on the same date revealed that Resident #3's most recent 1823 form dated indicated that Resident #3 needed assistance with medication but did not indicate the type or level of assistance was needed.

During an interview conducted on at 12:55 PM, the Resident Care Director said she did not know why the 1823 forms were not complete.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC

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SUMMARY STATEMENT OF DEFICIENCIES
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Based on interview and record review, the facility failed to correctly assist 3 of 10 sampled residents (Resident #1, Resident #7 and Resident #10) with self-administration of medication as described in F.S. 429.256. The facility did not tell a resident what medication they were getting, did not provide all prescribed medications to the residents as ordered and did not accurately document the assistance with medications on the Medication Observation Record (MOR).

Findings include:

During observation of a morning medication pass conducted on from 8:45 AM-9:30 AM, Employee A, an unlicensed Medication Technician (Med Tech) was observed assisting Resident #1 with self-administration of medications. Employee A gave Resident #1 Hydrazaline 50 MG, 40 MG and Benzaperil 10-20.
A review of the MOR for Resident #1 for 2014 revealed that Resident #1 was prescribed Lumigan .01% eye drops (one drop in the affected eye) every morning for
When Employee A was interviewed at 9:45 AM, Employee A said he had forgotten to give Resident #1 the eye drops and would do so immediately.
When interviewed by telephone on at 9:25 AM, a nurse at Resident #1's physician's office stated that the eye drops were to slow/stop the progression of and said that if Resident #1 missed multiple doses over a period of time, the drops would not be effective.

A review of the MOR for Resident #7 for 2014 revealed that Resident #7 was prescribed 1 MG (milligram)/ML (milliliter) by mouth twice daily. The directions on the MOR stated "may place in drink or fluid." The MOR was signed/initialed for 8:00 AM and 8:00 PM doses throughout the month of

Resident #7 was interviewed on at 2:15 PM and when asked about assistance with self-administration of medication, stated "I don't get any medications. I don't like taking them so I don't take any when they bring it."

When interviewed on at 2:40 PM, Employee A stated that Resident #7 "gets her medication in her orange juice. We put it in in the morning before breakfast. If she knew it was in there, she wouldn't drink it." Employee A stated Resident #7 was given both daily doses of her medication without her knowledge.

On a review of the MOR for Resident #10 for 2014 revealed that Resident #10 was prescribed Omega 3 1,000 MG soft gel to take one capsule by mouth at bedtime. Resident #10 was also prescribed 10 MG tablet to take one tablet by mouth at bedtime for mood. Both of these medications were listed on the MOR for 8:00 PM. Both were initialed as having been given when the MOR was given after the morning med pass.
When interviewed at 9:47 AM, Employee A stated that he must have overlooked that the medications were for 8:00 PM and had accidentally given them to Resident #10 at the wrong time.

Class III

0091-Training - Documentation & Monitoring 58A-5.0191(12) FAC

Based on interview and record review, the facility failed to maintain accurate documentation of training reflecting the correct date, location and number of hours of the training for 2 of 3 sampled employees (Employee B and Employee C).

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Findings include:

During a review of Employee B's personnel record conducted on , it was noted that the record contained a training certificate for Employee B dated and titled "New Employee In-service Trainings." The certificate was signed by the owner of the facility. The agenda attached to the back of the certificate had multiple required in-service trainings listed and totaled 9 hours. Employee B's record also contained a training certificate for required training in also dated for 3 hours of training. The training certificate for was also signed by the owner of the facility. The total hours of training for was 11 hours.

The Resident Care Director was interviewed and stated that all employees are paid for completing required trainings. The Resident Care Director was asked to produce the payroll showing Employee B had worked 11 hours on and stated she could not locate the payroll.

The owner, who signed the training certificate, was interviewed by telephone on at 4:40 PM and stated that employees are provided with study materials and study at home after hours over the course of several days and are paid for that time.

Employee B was interviewed by telephone on at 9:50 AM and stated that when she was training, she worked normal shifts and observed other staff and reviewed training materials at home. Employee B stated she did not remember how many hours she worked on but said she was paid for her training.

During a review of Employee C's personnel record conducted on it was noted that Employee C's record also contained a training certificate dated for "New Employee In-service Trainings." The training agenda attached to the certificate dated and signed by the owner of the facility indicated the trainings lasted 8 hours.

The Resident Care Director was interviewed and was asked to provide the payroll for When the payroll record for the pay period was reviewed, it revealed that Employee C was not signed in as having worked on

Class

0163-Records - Resident, Penalties for Alteration 429.49 FS

Based on observation and record review, the facility failed to insure that the Medication Observation Records (MORs) for 10 of 10 sampled residents (Residents # 1-10) accurately reflected when the residents were assisted with self-administration of medication and took prescribed medications. The facility advised the unlicensed Medication Technicians (Med Techs) to sign the MORs for all previous shifts they worked indicating residents had taken prescribed medications. Failure to ensure the accuracy of MORs and sign MORs after the fact is falsification of resident records and puts the residents at risk of harm. Any person who falsifies any medical record of an assisted living facility can be charged with a second degree misdemeanor.

Findings include:

On at approximately 9:30 AM, while reviewing the MORs for the facility, it was observed that the

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MORs had a typewritten note on the cover. The note read, in part, "Attention all Med Techs The new M.O.R.s.... are in the medication books please be sure to sign them on the dates you worked.... Also if a medication is PRN and you gave it be sure to fill out the M.O.R. on the reverse side..." The note advised that this was per the owner of the facility. (Photo taken)

Employee A was interviewed at approximately 11:15 AM on [redacted]. Employee A stated he had just come back from vacation and had not signed the new MORs. Employee A stated that he wasn't sure he had worked as a Med Tech on any of the shifts where the MORs needed to be signed but he would have to check. Employee A stated the MORs referred to in the note were for previous shifts.

Employee B was interviewed on [redacted] at 11:10 AM. Employee B stated that she was advised there were a "lot of problems" with the previous MORs and so the owner got new MORs from the pharmacy. Employee B stated she had to sign the MORs for the facility's residents for previous shifts she'd worked. Employee B said she thinks she had to sign for about 4 different days she had worked over a 2-week period.

The Resident Care Director was interviewed on [redacted] at 2:45 PM. The Resident Care Director said the direction to sign the MORs came from the owner, who is a nurse. The Resident Care Director confirmed that the facility's pharmacy consultant and previous nursing consultant had advised them that MORs could not be signed after the fact.

Class II

0165-Risk Mgmt & QA; Adverse Incident Report 429.23 FS; 58A-5.0241 FAC
Based on interview and record review, the facility failed to report an adverse incident regarding an event reported to law enforcement for investigation involving one of eleven sampled residents (Resident #6).

Findings include:

During a review of the record for Resident #6, a progress note dated [redacted] revealed that Resident #6 had not returned to the facility by 10;00 PM after leaving at 8:30 AM. The note further indicated that the local police department was contacted.

On [redacted] at 11:30 AM, the brother of Resident #6 was interviewed by telephone and confirmed that he spoke with the police department late on [redacted] or early on [redacted] to let them know he had located Resident #6.

A review of online incidents for the facility was conducted and revealed that the facility had not reported any adverse incidents since 2011.

When interviewed on [redacted] at 2:25 PM, the administrator said he did not realize the situation with Resident #6 constituted an adverse incident and had not reported it.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Good Hope of Pinellas
7575 65th Way
Pinellas Park, FL 33781

Dear Administrator:

Re: **CCR# 2014001850 & CCR# 2014002130**

This letter reports the findings of two complaint surveys that were conducted on 10-14, 2014, by representative(s) 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(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

Enclosure: State (5000-3547) Form

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

, 2014

Bethel Health INC dba Good Hope of Pinellas
7575 65th Way
Pinellas Park, FL 33781
Attn: Chris Dembowski, Administrator

Dear Mr. Dembowski:

This letter reports finding of a complaint survey conducted from by representatives of the Agency for Health Care Administration. Within 10 business days from receipt of this letter, you are directed to comply with the tangible steps outlined below in order to correct the deficient practice. Attached are the deficiencies noted in the investigation.

The survey resulted in findings of noncompliance with the following areas:

1) **A 0163** – Resident Records – Penalties for Alteration - Class II
Your Assisted Living Facility failed to ensure that resident Medication Observation Records (MORs) were free of fraudulent documentation and accurately reflected staff assisting residents with self-administration of medication.

Your facility must comply with the following:

1) All facility staff providing assistance with self-administration **of medication** to residents must be re-trained on correct medication practices by a licensed pharmacist using the 2012 Assistance with Self-Administration Medication Guide released by the Department of Elder Affairs and available on their website at:
http://elderaffairs.state.fl.us/doea/publications.php.
This must be completed within 10 days from the date of this letter.

2) Your facility must develop a written policy outlining your facility's practices for unlicensed staff assisting with self-administration, including documentation on the MORs. **This must be completed within 10 days from the date of this letter.**

3) Your facility must contract with a consultant pharmacist or registered nurse not connected to the facility to audit your medications, medication carts and storage and medication observation records. The consultant shall also assist with the development of the policy noted in item #2. **This must be completed within 10 days of the date of this letter.**

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 contact **Paul Brown**, ALF Supervisor, at 727-552-2000.

Sincerely,

Paul M Brown

FOR Patricia Reid Caufman
Field Office Manager