STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967286	03/31/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Loving Care Of St Petersburg	1001 9th Street North Saint Petersburg, FL 33701	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:

0081-Training - Staff In-Service-03/31/2014

Revisit Repeat Tags:

0025-Resident Care - Supervision-58a-5.0182(1) Fac
0032-Resident Care - Elopement Standards-58a-5.0182(8) Fac

Specific Tag Findings:

0000-Initial Comments

Assisted Living Facility

A revisit was conducted on 3/31/14 to the complaint survey, CCR# 2013012668, of . This revisit was in conjunction with two other revisits.

Loving Care of St. Petersburg, assisted living facility, had uncorrected 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 knowledge of the resident's whereabouts for 2 (Resident #8 and #9) of 2 residents sampled for elopement.

Findings include:

Review of the facility's incident report for Resident #8 dated revealed that he had not been seen for 8 hours. The resident was not located when the hospitals and his family were called. The police was called for a missing person's report. The facility's incident report for Resident #8 dated revealed that the resident was not seen in the facility. The family, hospitals, and case manager were called. The resident was nowhere to be found. There was no indication that the police had been called. Review of Resident #8 ' s records revealed that he was admitted to the facility on . His nursing notes did not have any documentation related to the resident's elopement on . There was a nursing note dated which indicated that the resident was still missing, but had been spotted at a store by a non-staff member. The police were notified. It was not noted in the nursing notes when he returned to the facility. The next nursing note dated mentioned that the resident was not in the facility that morning to go to his doctor ' s appointment. He had been reminded to stick around because of the appointment, when he came and received money from his account on the 24th. There was no documentation about the time or circumstances related to the resident ' s return to the facility. There was also a nursing note dated which reported that the resident had not been there in 2 days. The police was called and a missing person ' s report was done. The resident ' s father was called. It also indicated that they needed to call his case manager. His nursing note on reported that the resident had returned to the facility late Friday which would have been . The resident ' s father and case manager were called on

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which was almost 3 days after his return.

Interview with the Staff B on / at approximately 1:20pm revealed that if a resident is missing, after the 8 hours is up, they call the police. They call the hospital, family members, and the case manager. The main one is Resident #8. He is not here often. He is always missing. He is here only 2 days a week. He went to the hospital this morning. He walked to the hospital. His nursing notes did not include any documentation about this resident going to the hospital the day of survey or the reason for the visit.

In the interview with the administrator on at approximately 3:25pm, he acknowledged the holes in charting about the resident's elopement.

Interview with Staff A on / at approximately 2:40pm revealed that Resident #9 had been gone since yesterday. He did not get his 8:00pm meds. She was going to do a missing person's report for him. The hospitals had not been called yet. She stated that they put down that the resident was absent from getting the medications on the medication observation records (electronic).

Review of the Resident #9's nursing notes revealed that there was no documentation about the resident being missing from the facility. The last note was dated .

In the interview with the administrator on / at approximately 4:00pm, he stated that he had talked to the assistant administrator about doing a better job with nursing notes.

Class III

0032-Resident Care - Elopement Standards 58A-5.0182(8) FAC

Based on record reviews and interviews, the facility failed to follow the policy and procedures for elopement for 2 (Resident #8 and #9) of 2 residents sampled for elopement.

Findings include:

Reviewed the facility ' s policy and procedure manual for elopement or resident location unknown, effective date and amended . It revealed that if a resident cannot be located at the facility promptly, and in no instance more than half an hour after the resident's whereabouts comes into question, the administrator shall contact the resident's family or responsible party to determine if the resident is with them. If the resident is not there, the administrator shall notify the family/ responsible party that the resident has eloped. The administrator shall immediately thereafter file a missing person's report with the police.

The resident's nursing notes and staff interview does not reflect this policy.

Interview with Staff B on / at approximately 1:20pm revealed that if a resident is missing, after the 8 hours is up, they call the police. They call the hospital, family members, and the case manager. Resident #8 is

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not here often. He is always missing. He is here only 2 days a week.

Review of Resident #8 ' s nursing notes dated revealed that the resident had not been at the facility for 2 days. The police was called and a missing person ' s report was done. The resident ' s father was called. The note also indicated that the resident ' s case manager needed to be called. His nursing note on reported that the resident had returned to the facility late Friday which would have been . The resident ' s father and case manager were called on which was almost 3 days after his return.

Interview with Staff A on / at approximately 2:40pm revealed that the Resident #9 had been gone since yesterday. He did not get his 8:00pm meds. She was going to do a missing person's report for him. The hospitals had not been called yet. She stated that they put down that the resident was absent from getting the medications on the medication observation records (electronic). Resident #9 ' s nursing notes did not have any information about the elopement or any calls made to family or police.

Interview with the administrator on / at approximately 3:25pm, he stated that the med techs reports the resident to missing persons, after they notice them missing for 8 hours. They do the elopement policy and a missing person ' s report.

Review of Resident #9 ' s electronic medication observation records revealed that he was absent for the 8pm medications on and the 8am and 12pm medications on . The last medications given to the resident were the 4pm meds on .

Even though Resident #9 was missing longer than 8 hours, the facility staff had still not tried to locate Resident #9.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

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

Dear Administrator:

This letter reports the findings of three state licensure survey revisits that were conducted on , 2014, by representative(s) of this office.

Attached are the provider's copies of the State (5000-3547) Forms, which indicate the deficiencies that were corrected and the uncorrected deficiencies identified relative to the revisits. Section 408.811(4), Florida Statutes, requires that you correct these uncorrected 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

Enclosures: State (5000-3547) Forms

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