STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968024	01/30/2015
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
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D

Specific Tag Findings:

Assisted Living Facility

Four unannounced complaint surveys, CCR# 2014012194, CCR# 2015000500, CCR# 2014011480 and CCR# 2014011772, were conducted on .....

The Bristol Court assisted living facility had deficiencies cited at the time of the visit.

CCR#2014011480 and CCR#2015000500 had deficiency A0025 cited.

CCR#2010500, CCR#2014011480 and CCR#2014011772 had deficiency A0030 cited.

CCR#2014012194 did not have any deficiencies cited.

There were two unrelated deficiencies cited, A0052 and A0055.

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

Based on observation, interview and record review, the facility failed to provide appropriate supervision for residents who go outside to smoke or visit the courtyard.

Findings Include:

Footage from a closed circuit security camera (there is a camera in the courtyard area) was reviewed on ..... at 1:45 pm and it revealed on ..... at 7:20 am, resident #4 was walking toward his garden area in the courtyard when he saw resident #17 walking toward him. There was an exchange of words as resident #17 got closer. The two stopped and there were a few words exchanged and then resident #4 swung at resident #17 and missed. Resident #17 reacted by hitting back and then he threw resident #4 on the ground and kept beating on him until he finally stopped and got off the resident. The fight lasted about 45 seconds. Another resident was seen coming back into the facility and he must have called the staff because three staff members, all from the first floor, showed up and kept the two residents separated. Resident #17 came back towards resident #4 who had gotten up off the ground. There was no staff present on the video, until the resident came and got them.

A record review of the health assessment on ..... for resident #4 revealed his diagnoses as ..... knee replacement done in 2005 & 2008, left eye injury (accident in 1975), ... hearing aid (left & right) and ..... The resident needed assistance with all activities of daily living and needed assistance with medication. He was admitted to the facility on ..... and discharged on ..... to his daughter's home.

A record review of the resident #4's medical record and hospital records on ..... revealed the resident went to the hospital at 8:30 A.M. He was assaulted at the ALF and brought to the emergency ..... ambulance.

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He stated at the hospital that he was defending his garden. The hospital records show resident #4 had multiple lacerations on his face and hands. Two of the facial lacerations required his lower lip and left temple. A facial CT was done, no acute The final diagnoses were: Assault, head injury, lip laceration, tears and facial lacerations. He was discharged back to the ALF on at 12:30 P.M.

A record review on of the health assessment for resident #17 revealed his diagnoses as memory loss, tobacco dependent, and He needs assistance with all activities of daily living and medications. The health assessment stated he was alert and oriented times 3 and a risk. He lives on the second floor where the lower functioning residents reside. He was admitted to the facility on and discharged from the facility on

The staff which came out to help after the fight was over were: staff #C, staff #F and staff #G. Both staff #F and staff #G no longer work at the facility. Staff #C is the only staff still working at the facility who helped the resident after the fight.

Staff #C stated on at 2:35 pm the fight happened early in the morning around 7:20 am. That is the time we are all very busy getting the residents ready for breakfast. We don't have enough time to be outside watching the residents smoke. We are told to check on the residents every two hours but I try to get out there at least every hour. I just do a quick look before going back inside. Any of the residents can go outside to smoke even the ones from the second story. The residents on the first floor are pretty high functioning and the ones on the second floor are lower functioning. They are all out there together when they smoke or just want to go outside.

The courtyard was observed on at 9:30 am and there was no staff present. There were residents outside in the gazebo smoking. The courtyard was observed again on at 3:00 pm and there was no staff present. There were residents observed walking to and from the gazebo in the courtyard area.

Resident #2 stated on at 4:40 pm stated there are fights here all the time, inside and outside, it doesn't make any difference. No one watches us especially outside.

On an observation of resident #9 not being supervised at 2:08 pm, revealed resident #9 was carrying around a container of wiping cloths used for resident peri care on the east side of the building, second floor. He had apparently taken them out of a supply area and the direct care staff had to talk him into giving them back to her.

The facility has a census of 98 on and this is made up of and residents as well as limited mental health residents. All of these residents are allowed to be outside in the courtyard smoking or just walking around. The residents are unsupervised while in the courtyard. By the time staff got outside to stop the fight between resident #4 and resident #17, resident #4 already had multiple

The administrator stated on at 2:00 pm when interviewed by phone, we have the staff check on the residents at least every two hours inside and outside. We try to know what they are doing but that doesn't always happen. We do have a camera outside and we try to monitor it during the day. We are going to have to try and figure a way to better supervise the residents outside.

Class III

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS

Based on observation, interview and record review the facility failed to honor residents' rights for the entire facility's ninety-eight residents to live in a safe and decent environment free from bedbugs. Specifically, the facility failed to adequately address an ongoing infestation of bedbugs at the facility. The outcome is residents are living in an environment where they are bitten by bedbugs daily and some have had to go to the hospital for treatment.

Since the facility has failed to provide the residents with a clean and decent living environment, this has directly threatened the physical and emotional health of the residents living at the facility.

Findings Include:

During a telephone interview on at approximately 10:00 A.M. with an environmental supervisor from the local Department of Health, he confirmed the facility has had an ongoing problem with bedbugs. The supervisor stated they have recommended the facility contract with a professional pest company. He stated bedbugs are in the facility walls and they move from Spraying is not effective at this time.

An e-mail dated from the Environmental Supervisor II from the Department of Health stated when she looked back at the complaint log and at past inspections, she confirmed that the complaints for bedbugs have been ongoing since 2013.

The most recent inspection dated confirmed the facility still had an infestation of bed bugs and there were recommendations and suggestions for treatments.

During record review of the Health Department's inspection reports for the facility revealed the last inspection dated was unsatisfactory. The violation #27 infestation/Presence was noticed. The Health Department reported observation of live infestation and recommended the facility use a professional service to treat the entire second floor.

The report stated the facility had to correct the following: treat, clean, and sanitize all floors, walls, clothing, furniture, and bedding in the Observed live bed bugs in indicated. Professional services are recommended. Clean and sanitize Especially along walls. observed, bugs in indicated.

The last invoice from Orkin Pest Company dated shows they treated only three of the listed on the health departments report. They treated 204, 221 and 207. The assistant administrator stated on at approximately 2:00 PM that he had treated the rest. He stated the reason he does the treatment for most of the is because he does a better job. He treats the residents' and furniture and has even had to throw away some residents' clothes. He stated that he buys products from the store and sprays the He uses a powder that is sold over the counter to kill bedbugs and treats wall plugs and light fixtures in the residents' He stated that he knows the products available are not as powerful as what the professionals use but they have been able to help reduce the bedbug problem.

An observation and interview was conducted on with Resident # 11 at approximately 11:30 A.M. There were sheets with small black bugs and spots of dried observed on the resident's bed (photo taken). The resident thought the was a result of an reaction from medication she had been taking. During the interview, the resident would not allow the nurse surveyor to look at or photograph the on her back.

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An interview was conducted with Resident #10 at approximately 11:30 A.M. The resident stated she had been treated for bedbugs and head . . . The resident stated the facility had even thrown away some of her . . nate's clothes. The resident stated the bugs keep coming back.

An observation and interview of Resident #8 at approximately 3:00 P.M. revealed bites all over his torso and left elbow. The resident allowed a nurse with the survey team to take a photograph. There were red raised areas that appeared to be similar to insect bites, with scratch marks where he had been scratching. The resident stated the staff knew about the . . . but was not doing anything about it.

Record review for Resident #1 on . . . . . revealed the resident went to a local hospital for multiple bedbug bites to his back. The hospital gave him . . . to control the itching because an . . . . can develop if the bite is scratched and the skin is broken.

When interviewed on . . . . . at 5:45 P.M., Resident #1 stated the bedbugs are still here. "I don't think they will ever go away".

Record review for Resident # 2 revealed the resident was sent to the hospital on . . after complaining of a . . . . The resident told the emergency . . . . . he had been seen by a dermatologist after living at the facility a couple of days. The dermatologist told the resident the . . . . was from bedbugs. The hospital documentation identified the cause was possible bed bugs.

An interview was conducted on . . at approximately 12:40 P.M., Resident #2 reveals he had concerns related to bed bugs from a few months back in . . 2014. He went to the hospital and was treated for bedbug bites. The resident stated he received treatment, again, on . . . . . at a local hospital for bed bug bites. He also stated he had recently seen bed bugs in multiple resident . . . .

An interview was conducted with direct care Staff A on . . . . . at 12:40 PM and she stated she had been employed at the facility for a couple months. Staff A worked from 7:00 A.M. to 3:00 P.M. Monday- Friday showering the residents. She stated the residents have complained of bed bugs and head . . . She stated she had been applying medication to the residents, but, it seems the problem kept coming back. Staff #A confirmed some of the residents had rashes and head . . Lots of residents have expressed to her that they have bed bugs in their bed and . . . . . and they are being bitten at night. " I have seen them myself crawling around resident . . Staff A stated in . . 2014, Resident #2 had a really bad . . . on his back and shoulder areas. She believed they were from bed bugs. She related this information to management. Staff A stated, until the bedbugs are completely gone, she will continue to use a body oil that prevents the bedbugs from biting her. "I haven't been bitten yet".

The Staff A identified Resident # 11 as a resident that she had recently treated for head . . . . The staff A stated the resident also had a . . . on her torso.

Due to the facility's inability to follow the health departments recommendations, residents interviews regarding being bitten by bedbugs and record reviews of residents' hospital visits pertaining to bedbug bites, the facility failed to provide the residents with a clean and decent living environment which has effected their physical and emotional well-being.

Class II

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

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

Based on observation, interview and record review, the facility failed to ensure medication assistance with self-administered medications was performed according to the statue and within staff training guidelines by not telling the resident what the medications were for, letting the resident see the medication card, and putting another resident's medication in a cup and placing it in the top drawer of the medication cart to wait for the resident to come and get it.

Finding Include:

During a tour of the first floor east wing, a med tech Staff E was observed with 2 medication cups in her hand, one inside the other, in her other hand, a glass of water. She gave one cup to the Resident, placing it in his hand while he was seated in the hallway, which left one medicine cup in her hand, and encouraged the resident to take the pills, handing him the glass of water she had in her other hand. "Here's your water, drink up" she said. The resident then took the pill cup and then drank the water she had handed him. Staff E walked over to the medication cart inside the nurse's station and placed the remaining medication cup in the top drawer of the cart. She was asked why she didn't give the other cup to the Resident and she stated that it wasn't for him, and the Resident it was intended for was not close by anyway.

A record review of Staff E training showed that she had taken the four hour medication training course and was up to date on her training.

Class III

0055-Medication - Storage and Disposal 58A-5.0185(6) FAC

Based on observation and interview the facility failed to maintain best [redacted] control practices by keeping a stool sample in one medication refrigerator on one (1 East) of four medication [redacted] in the facility. The facility also failed to store discontinued medications in a central location without the area being marked as "discontinued medications " for one (1 East) of four medication [redacted] located in the facility.

Findings Include:

On [redacted] at 115 p.m., during an interview with the Nurse, when she was asked if there were any [redacted] residents in the facility, she stated that the Doctor checks the A1C [redacted] glucose look -back test), then if its good, the Doctor will discontinue the [redacted], if the resident's [redacted] can't be controlled, they will discharge the resident.

On [redacted] at 2:15 p.m. an inspection of the medication [redacted], including the refrigerator, occurred with the Resident Care Director on 1 East. It was observed and confirmed, with the Resident Care Director, that three [redacted] vials were found in the refrigerator, along with a stool sample, and a medicated injection. The Resident Care Director stated that somebody must have just put that in there (stool sample), I think its 20 minutes old.

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A record review of the Control Policy, undated states "It is the policy of this facility to follow practices of control and universal precautions". A statement under "Procedure" states contaminated items are to be handled properly".

A record review of resident #1 reveals that the was discontinued on , 2014. The order was written on a prescription of the Doctor on staff at the facility. The was prescribed by the Doctor at another hospital when he was admitted on . Since the was centrally stored by the facility, the discontinued medication must be stored separately from medication in current use, and the area in which it is stored must be marked "discontinued medication".

In an interview with the Assistant Administrator at 6 p.m. on , he stated that he didn't know anything about it, and that he would investigate the matter.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2015

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

RE: CCR#2014012194, CCR#2015000500, CCR#2014011480 and CCR#2014011772

Dear Administrator:

This letter reports the findings of a complaint survey that was conducted on . 2015 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,

Paul Brown

for Patricia Reid Caufman
Field Office Manager

PRC/src
Enclosure: State (5000-3547) Form

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

. 2015

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

Dear Administrator:

This letter reports the findings of complaint 2014012194, 2015000500, 2014011480, and 2014011772 inspection surveys conducted on . 2015, 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 **thirty business days** of receipt of this hand delivered report.

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

St - A - 0000 - - Initial Comments
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
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0055 - 58a-5.0185(6) Fac - Medication - Storage And Disposal S-S= D

The Agency for Health Care Administration is imposing a directed plan of correction (DPOC). Bristol Court agrees and accepts this DPOC. Should Bristol Court fail to comply with the DPOC, submit an acceptable plan of correction, and/or achieve substantial compliance, the Agency for Health Care Administration may take administrative action including termination of its Assisted Living license.

Directed Corrective Actions:

You are directed to perform the following:

1. Bristol Court will engage the services of a professional pest control company to eradicate bed bugs from the facility.

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

2. The entire facility must be treated in the appropriate manner, with heat or a pesticide of the appropriate strength to kill/remove bed bugs.

3. The County Health Department must confirm, after treatment, the facility is free of bed bugs.

4. An approved plan of correction must be submitted to the Agency for Health Care Administration that outlines how the facility will monitor, on a daily basis, and maintain an environment free of bed bugs by . 2015

5. The facility must develop a plan of correction that outlines how they will ensure residents admitted to the facility in the future do not bring bed bugs on to the premises by . 2015.

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 . **Laura Manville**, Survey and Certification Support Branch, at (727) 552-1955, or **Paul Brown**, Area 5/6 HFES, (727)552-2000

Sincerely,

Paul Brown

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

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) 552-1162