AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932424	10/26/2015
NAME OF PROVIDER OR SUPPLIER **CENTRAL ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **2349 CENTRAL AVENUE SAINT PETERSBURG, FL 33713**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Assisted Living Facility

A complaint survey, CCR# 2015010026, was conducted in conjunction with a revisit to the biennial state licensure survey of / .

Central Assisted Living Facility had deficiencies at the time of the visit.

0054 Medication - Records

Based on interview and record review the assisted living facility failed to maintain an accurate and up to date Medication Observation Records (MORs) for 4 of 4 sampled residents (Resident #4, #5, #6, and #7) that were assisted by staff with self-administration of medication.

Findings include:

A record review of Resident #4 ' s 2015 MOR revealed no signature to confirm the medication 0.5 MG ordered " take 1 tablet by mouth three times a day " was given on - 5:00 PM, - 12:00 PM and - 12:00 PM. No explanation was documented on the back of the MOR sheet.
A record review of Resident #5 ' s 2015 MOR revealed no signature to confirm the medication 1,000 MG tablet ordered " take 1 tablet by mouth twice daily for " was given on - 5:00 PM. No explanation was documented on the back of the MOR sheet.
A record review of Resident #6 ' s 2015 MOR revealed no signature to confirm the medication Proair HFA 90 mcg, actuation HFA AER AD ordered " inhale 2 puffs by mouth 4 times a day was given on / / - 5:00 PM, / and / - 5:00 PM and 8:00 PM. No explanation was documented on the back of the MOR sheet.
A record review of Resident #7 ' s 2015 MOR revealed no signature to confirm the medications 325 mg, ordered " take 1 tablet by mouth every day " , 10 mg, ordered, " take 1 tablet by mouth every day " , Nifedipine kl 30 mg, ordered, " take 1 table by mouth every day " and Nephro - Vite tablet, ordered " take 1 tablet by mouth every day " were given on / / at 8:00 AM. No signature to confirm the medication 100 mg ordered, " take 1 caps by mouth 2x day " was given on / / , / and / at 8:00 PM. No signature to confirm the medication 20 mg ordered, " take 1 ½ tablet by mouth daily " was given on / and at 8:00 AM. No signature to confirm the medication 10 mg tablet ordered, " take 1 tablet by mouth three times a day " was given on / at 8:00 PM.
On at 11:45 AM an interview was completed with Employee A and B. Employee A stated she

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did not know if the medications on the reviewed MORs were given or not. Employee A was asked to retrieve the medication bubble packs for Resident #7 ' s Nifedipine KL 30 mg tablet, and Nephro Vite Tablet. Employee A stated she was unable to locate the bubble packs.
A review of Resident #7 ' s MOR revealed that Resident #7 ' s was marked as given on and every day prior.
Further interview with Employee A was completed on at 11:45 AM. Employee A stated Resident #7 " did not get his medication this morning " and stated she should have circled her initials on the MOR. Employee A stated the medication was also marked off as given the day before but stated Resident #7 was not at the facility on .
On at 11:45 AM an interview was completed with Employee D. Employee D stated Resident #7 ran out of medication about a week and a half ago.

Class III

L241 LMH - Records

Based on interview and record review the Assistant Living Facility failed to obtain an annually updated community living support plan for 3 of 3(Resident #1, #2 and #3) sampled residents.

Findings include:

A record review of Resident #1, #2 and #3's chart revealed community living support plans dated (Photographic evidence obtained)
On at 5:00 PM an interview was conducted with the Assisted Living Facility Administrator regarding the reviewed Community Living Support Plans for Residents #1, #2 and #3. The Administrator reviewed the plans and confirmed that the Support Plans needed to be updated.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Central ALF
2349 Central Avenue
Saint Petersburg, FL 33713

RE: Revisit & **CCR# 2015010026**

Dear Administrator:

This letter reports the findings of a state licensure revisit survey and a complaint survey that were conducted on 26, 2015, by representative(s) of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiency was found corrected, and the State (5000-3547) Form, which indicates the deficiencies that were identified relative to the complaint survey. 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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.

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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