**AGENCY FOR HEALTH CARE ADMINISTRATION**

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | AL11968554 | 12/29/2015 |
| NAME OF PROVIDER OR SUPPLIER<br>**CHRISTOPHER'S PLACE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**3586 53RD AVE NORTH**<br>**SAINT PETERSBURG, FL 33714** | |

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

**0000 Initial Comments**

Assisted Living Facility Licensure

A biennial state relicensure survey with Limited Mental Health (LMH) and Limited Nursing Services (LNS) was conducted on . Christopher's Pace, Assisted Living Facility, had deficiencies at the time of the visit.

**0008 Admissions - Health Assessment**

Based on observation, interview and record review, the facility failed to ensure completion of the required 1823 Health Assessment Form for 2 of 3 resident record reviews completed. (Resident #7 and Resident #9).

Findings included:

The resident record for Resident #7 contained a Form 1823 that did not contain the type of assistance needed for meds. The Form 1823 stated "see med recs#. No records were attached anywhere.
In addition, the following sections were not completed;
ALF "not require 24 hour nursing/psych supervision" was not checked yes or no.
Any nursing or services required by the individual said none. The resident is receiving the services of Hospice at the present time.
MD states " needs can be met in an ALF" was not checked yes or no.
The type of assistance needed for meds was not filled out and whether the resident needed assistance with self administration of medications or medication administration were not marked for Resident #9.
An interview with the administrator was conducted at 1:00 PM. She acknowledged that the items were missing.

Class III

**0026 Resident Care - Social & Leisure Activities**

Based on observation and interviews, the facility failed to provide an ongoing activities program with consultation from the residents for selecting, planning and scheduling.

Findings included:

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6 of 6 residents interviewed stated that there are no activities taking place at the facility and that there is no activity calendar posted. The facility does not have any type of resident council meetings or group discussions in order to get residents input or suggestions for activities. 3 of the 5 residents interviewed stated that it would be nice to have something going on.

A tour of the facility was conducted between 10:00 A.M. and 5:00 PM. An activity calendar was not posted anywhere in the facility during that time. No activies were observed taking place.

An interview was conducted with the Administrator at 2:30 P.M. She stated that it is hard to get the residents interested in activities. She confirmed that there is no official means of consulting with the residents for their input, but stated that she is always available for suggestions. She confirmed that an activity calendar was not posted and did not post one during the course of the survey.

Class III

**0054 Medication - Records**

Based on observation and a review of facility Medication Observation Records (MORS), the facility failed to maintain the daily MORS for 2 of 3 resident records reviewed. (Resident #2 and Resident #5).

Findings included:

Resident #5 did not have anything on the MOR but the name of the medication and the residents name. Resident #2 did not have anything on the MOR but the name of the medication and the residents name for his " as needed " pain medication.
An interview was conducted with the administrator at 1:30pm. She acknowledged the omission of the following information from the MOR : any known the resident may have; the name of the resident ' s health care provider, the health care provider ' s telephone number, strength, and directions for use of each medication.

Class III

**0078 Staffing Standards - Staff**

Based on interview and personnel record reviews, the facility failed to ensure that 3 of 4 staff whose files

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were reviewed, and who were employed longer than 30 days, had either been been examined by a health care provider or had evidence of a negative examination in order to ensure they had no signs or symptoms of communicable . (Staff A, B and C).

Findings included:

Staff A, the Administrator, had a form in her personnel file that was signed by a health care provider, that said free from communicable with a box marked "only with screen". There was no evidence of a screen. She stated that she had a chest x-Ray but could not provide evidence of such.

Staff B was hired / . The last statement from a health care provider of evidence of no signs or symptoms of communicable was dated . The administrator confirmed that the employee had not had a subsequent exam or a statement from a health care provider ensuring she is free from communicable .

Staff C was hired / . There was no evidence of freedom from communicable nor was there evidence of a negative examination.

The administrator did not offer any other evidence of compliance with this requirement.

Class III

**0081 Training - Staff In-Service**

Based on interview and a review of the personal files, the facility failed to ensure that 1 of 4 staff who provides direct care and has been employed for longer than 30 days (Staff D) had received the required training.

Findings included:

Staff D was hired on . There was no evidence that he had received training within 30 days of employment in the following areas;

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1. Resident rights in an assisted living facility.
2. Recognizing and reporting resident , neglect, and
3. Resident behavior and needs

An interview was conducted with the Administrator at 3:30 P.M. and she stated that the employee may have received the training and that she would ask him for evidence and send it to the surveyor the next day. No evidence was received by the surveyor.

Class III

**0093 Food Service - Dietary Standards**

Based on observation and interviews, the facility failed to post or make available the daily menu for residents.

Findings included:

6 of 6 residents interviewed stated that they have never seen a menu posted in the facility. They just eat what is put in front of them. In addition, one resident stated that he has seen others ask what they are having and that the staff states "whatever I put in front of you". He said that everyone just eats what is served because they don't want the staff to get "an attitude". There is no way of knowing if the planned and approved menus are served. On the day of the survey, ravioli, green beans garlic bread yogurt and milk were supposed to be served. The facility substituted with an open face pork sandwich, baked beans, yogurt, and potato salad. There was no milk in the facility. The substitution log was completed.

A tour of the facility was conducted between 10:00 A.M. and 5:00 PM. The only menu that was observed, was in the kitchen, which is" off limits" to the residents. An interview was conducted with the Administrator at 2:30 P.M. She stated that she did not know that the menus had to be posted in the dining . She confirmed that the menu was not posted and did post one during the course of the survey.

Class III

**0160 Records - Facility**

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Based on interview, observation and a review of the facility's admission/discharge log, the facility failed to maintain an up-to-date log of all admissions and discharges.

Findings included:

Upon entrance to the facility at 9:15 A.M. on , Staff B was asked what the current census of residents living in the facility was. Staff B stated that she thought it was 14. When the Administrator arrived, she was asked what the current census was and she stated 15.

A review of the Admission/Discharge log revealed 16 residents in the facility but one resident who was selected for the sample was not listed on the log. A closer review of the log was completed with the Administrator at 10:30 A.M. It was discovered that Resident #1 was not listed which would bring the total number of residents to 17 which is over the licensed capacity. The Administrator discovered a resident name on the log who had been discharged and was no longer in the facility. The log did not contain any discharge information for this resident. The final current number of residents in the facility was determined to be 16.

In addition, the 4 most recent resident admissions to the facility did not contain either the date of admission or the place from which the resident was admitted.

The Administrator confirmed that the above information was not current or complete.

Class III

**L243 LMH - Training**

Based on interview and a review of personal files, the facility failed to ensure that 3 of 4 staff (Staff B, C and D) had received the required training in mental health issues. The facility is licensed for Limited Mental Health (LMH) services.

Findings included:

The personnel file for Staff B, hired on / , contained a certificate of training in mental health for

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only 3 hours dated . There was no other evidence that Staff B had received 6 hours of training provided by or approved by the Department of Children and Families.

The personnel file for Staff C, hired on / , contained a certificate of training in mental health dated / . . This is not within 6 months of the facility obtaining their limited mental health license. There was no other evidence that the training she had received was within 6 months of employment at a limited mental health facility.

The personnel file for Staff C, who was hired on contained no evidence of any mental health training. The facility obtained their limited mental health license on / .

An interview was conducted with the administrator at 3:30 P.M. She confirmed that the required training was not in the files.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Christopher's Place
3586 53rd Ave North
Saint Petersburg, FL 33714

Dear Administrator:

This letter reports the findings of a biennial state licensure survey with limited mental health (LMH) and limited nursing services (LNS) 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. **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 , 2016.** 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 Form 5000-3547