STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967604	R
NAME OF PROVIDER OR SUPPLIER **GOOD HOPE OF PINELLAS**	STREET ADDRESS, CITY, STATE, ZIP CODE **7575 65TH WAY** **PINELLAS PARK, FL 33781**	

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

0000 Initial Comments

Assisted Living Facility

A 2nd revisit to a complaint survey, (CCR# 2016001791), was conducted from I/ through , at Good Hope of Pinellas, license #11615, 7575 65th Way, Pinellas Park, FL. The facility had uncorrected deficiencies at the time of the visit.

0152 Phvsical Plant - Safe Living Environ/Other

Based on observation and interview the facility placed 22 out of 22 residents at risk when they failed to ensure the fire exit doors were in proper working order. Additionally, the facility failed to provide a safe and clean living environment for 22 out of 22 residents. Specifically, the facility failed to repair leaks in the roof throughout the facility, failed to provide hot water for residents to shower, failed to ensure resident had working toilets, and failed to provide toilet paper and paper towels in public and resident .

Findings included:

On I/ at 10:15 AM a tour and interview was conducted with the Fire Inspector who arrived to conduct the Fire Safety Inspection. He stated the double exit doors closest to the Administrator ' s office were chained closed and stated as a fire hazard " that ' s big " , and that must be corrected within 24 hours. He stated the doors in the southwest wing and the north wing would not open at all and must be corrected today. He further stated three sets of double doors did not have the panic release bar, and they must be installed, and one set of double doors had the panic release bar painted over and it was stuck and must be corrected. He stated the refrigerator was plugged into a power strip instead of directly into the wall, which was a fire hazard. The Fire Inspector stated too many appliances were plugged into a power strip in the kitchen storage . In addition, the alarm system and the suppression (sprinkler) system were both out of date. " That ' s bad. " The risk on his report was listed as " high " .
On at 1:25 PM an interview was conducted with the Administrator. The Administrator stated the chains had not been removed from the fire exit doors, the alarm system and suppression system (sprinkler) system had not been re-inspected, and the rest of the items cited in the Fire Inspector ' s report had not yet been corrected either.
On at 1:45 PM an interview was conducted with the Fire Inspector. The Fire Inspector stated the chains should have been removed from the fire exit doors the same day of his initial visit, I/ .
On at 10:44 AM an interview was conducted with the Fire Chief. The Fire Chief stated he

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

went to the facility this morning, and inspected the fire exit doors that had been cited on the Fire Inspection report on / as not being able to open, which they were given 24 hours to correct. He stated the Administrator had been unable to open any of those doors.
On at 3:46 PM an interview was conducted with the Administrator. The Administrator stated the panic release bars had not been put on the fire exit doors as instructed by the Fire Department on /. The Administrator was not able to provide a date by which the item would be corrected.
On / at 9:55 AM a tour was conducted of the facility. A large leak was observed in the Administrator ' s office close to the door. There were two towels on the floor that were soaked, and a puddle had formed around the towels. When questioned if this was the only leak in the building, the Administrator stated " they are everywhere. " Two large leaks were observed in the kitchen. There was free standing water that was deep enough to soak the lower one inch of surveyor ' s pants. A trash can had been placed underneath the leak by the stove. It had several inches of water in it. A roach was observed in the the kitchen. Another roach was observed in the middle of the floor of the kitchen food storage . The back resident hallway had a major leak, and a large puddle was observed in the middle of the hallway where residents and staff must walk. Above the puddle was a vent that was dripping water and appeared to have a black substance believed to be mold. A second leak was observed with a puddle on the floor beneath wet ceiling tiles. A leak was observed in resident # . A towel was on the floor, but the towel was soaked and the water had pooled by the .
On / at 9:56 AM an interview was conducted with Resident #4. Resident #4 stated he has no hot water in his he has to use warm water from his sink to wash himself. He stated it has been so long since he had hot water in his shower he is getting used to it.
In a continued tour of the facility, four resident were sampled for working plumbing and water. The toilet in resident # did not flush. Feces and were observed in the commode. The shower in # had no hot water. The toilet in resident # was running. The shower shared by resident #21 and #23 had no hot water. The shower in # had no hot water. The public the back hallway had no toilet paper or paper towels. The toilet was running. The staff the Administrator ' s office had no toilet paper or paper towels. The public to the Administrator ' s office had no toilet paper or paper towels and had strong odor of . Several resident were checked for toilet paper, and multiple resident did not have toilet paper.
On / at 12:33 PM an interview was conducted with the Administrator. She stated they had an adequate supply of toilet paper and paper towels. She was unsure why they had not been stocked. The Administrator stated the housekeeper was supposed to keep them stocked. The Administrator stated Staff C was supposed to be direct care staff today, but the cook called in sick and so did the housekeeper, so Staff C was currently working all three positions. Staff C had cooked breakfast and then began doing her normal duties while also trying to clean.

Class II

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967604	R
NAME OF PROVIDER OR SUPPLIER **GOOD HOPE OF PINELLAS**	STREET ADDRESS, CITY, STATE, ZIP CODE **7575 65TH WAY** **PINELLAS PARK, FL 33781**	

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

0181 Emergency Plan Approval

Based on interview and record review, the facility failed to submit to the local emergency management agency for review and approval its emergency plan on an annual basis.

Findings included:

On / at 10:15 AM an interview was conducted with the Fire Inspector. He stated he had come out to the facility last week to review the emergency management plan and he was told it wasn't ready yet. He returned today to review it, but was told it was not ready.
On / at 10:16 AM a record review was conducted of the emergency management plan. The Administrator stated she had not had a chance to finish it and it has not yet been reviewed and approved.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967604 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD HOPE OF PINELLAS	7575 65TH WAY PINELLAS PARK, FL 33781

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix AZ814 Reg. # 435.12(2)(b-d). FS LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) PJB	DATE 9/19/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/25/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

EVENT ID: CT8713

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Bethel Health INC dba Good Hope of Pinellas
7575 65th Way
Pinellas Park FL 33781

Dear Administrator:

This letter reports the findings of a complaint survey conducted 31- , 2016, by representatives of the Agency for Health Care Administration. 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 request as directed below:

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

A0152 – Physical Plant – Safe Living Environment. **Class II.**
A0181 – Emergency Plan Approval. Uncorrected **Class III.**

The facility must comply with the following:

1) Your facility must correct all deficiencies cited in the Pinellas Park Fire Department inspection dated / / . This must be completed **IMMEDIATELY.**
2) The facility must have the roof inspected and repaired to ensure that the roof is free of leaks. The facility must comply with local authorities regarding the repairs to ensure the work is legally permitted and completed by a licensed contractor. This must be completed by **, 2016.**
3) All that have a shower must have hot and water. All toilets in the building must be operable. All in the facility must contain toilet paper, paper towels, and soap. This must be completed by **, 2016.**
4) The facility must provide copies of satisfactory inspections by both the fire department and the health department. This must be completed by , **2016.**

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**, St. Petersburg Field Office, (727) 552-2000.

Sincerely,

Paul F Brown

for Paul F. Brown
Health Facility Evaluator Supervisor