STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11932390	09/22/2016
NAME OF PROVIDER OR SUPPLIER **AMELIA ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **2135 40TH AVENUE N.** **SAINT PETERSBURG, FL 33714**	

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

0000 Initial Comments

Assisted Living Facility

A monitoring visit was conducted on at Amelia ALF, 2135 40th Ave North, St. Petersburg, FL, License #1052. Amelia ALF had deficiencies identified on the day of the survey.

0052 Medication - Assistance with Self-Admin

Based on observation and interview the assisted living facility failed to provide assistance with self-administration of medication per the requirements in 429.256, F.S. The facility failed to ensure qualified staff provided assistance with self-administration of medications by reading the label and opening the container in the presence of the resident, failed to ensure staff watched the resident take the medication, and failed to document the resident received the medication after the medication was given to 3 out of 3 (Residents #1, #2, and #3) sampled residents.

Findings included:

On at 7:40 AM an observation was conducted of Staff A as she placed a cup of medications and a cup of water on the ledge at the pass-thru window from the medication . Staff A turned her back to the resident and did not watch Resident #1 take the medications. Staff A did not tell Resident #1 the name of the medications. Staff A was observed as she removed the medications for Resident #2 from the cart. She did not use gloves or wash her hands in between residents. Staff A placed the medications into a cup and placed the medications and a small cup of water up on the ledge Staff A did not tell Resident #2 the names of the medications she was taking, and did not watch her take the medications. Staff A turned her back to Resident #2 and signed the electronic medication observation record (MOR). Resident #2 was unable to get one of the pills out of the medication cup. Resident #2 asked Staff A for assistance without response. Resident #2 asked a second time for assistance without response. Staff A was observed wearing headphones attached to the phone she had in her pocket. Staff A popped out two pills for Resident #3 from a medication card onto the top of the medication cart. Staff A used her bare hands to pick up the medication and place it into a cup. Staff A signed the electronic MOR for Resident #3, then put the medications and a cup of water on the ledge. Staff A turned her back to Resident #3 and began getting medications out of the cart for the next resident. Staff A did not watch Resident #3 take her medications or tell her the names of the medications. (Photo 26)
On at 8:00 AM an interview was conducted with Staff A. Staff A stated she had not heard Resident #2 request assistance. She stated she is in one ear, and realized she should not have been wearing headphones while working. Staff A stated she has obtained the required 4-hour assistance

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with the self-administration of medications training, and was aware that she was required to sign the MOR after watching the resident take the medication.
On . . . at 8:45 AM an interview was conducted with the Facility Director. She stated Staff A should be aware that the MOR is not to be signed until after the resident has been observed taking the medication, and should be using proper sanitizing techniques. The Facility Director stated Staff A would be counseled in how to properly assist with the self-administration of medications.

Class III

0152 Phvsical Plant - Safe Livina Environ/Other

Based on observation and interview, the facility failed to provide a safe and clean living environment for 19 out of 19 residents. Specifically, the facility failed to prevent or eradicate bed bugs in the resident , failed to follow the pest control company ' s instructions for prior to bed bug treatment, failed to maintain a safe and sanitary kitchen for preparation of resident meals, failed to make needed repairs to maintain the safety of the facility, and failed to provide linens free of tears and stains.

Findings included:

On . . . . . at 7:40 AM an observation was made of a substance by the front door that appeared to be . . . . . (Photo 1)
On . . . . . at 8:00 AM an interview was conducted with Staff A who was in a locked medication with the self-administration of medications to the residents in the facility. Staff A stated she is the only employee currently working in the facility. Staff A stated all employees were cross-trained and were expected to clean on each shift.
On at 8:30 AM during a tour of the facility, the following observations were made: the sheets in resident . . . . # . were stained on one side and stains that appeared to be were observed on the other side; the floor in resident . . . . # was dirty and did not appear to have been cleaned in some time; the window in the hallway across from the medication easily accesible to the residents was broken and covered with plastic; the phone designated as the resident's phone had a black substance in the cradle where the earpiece rests; the oven in the kitchen was smeared with an unknown substance; the microwave had a broken handle and had a strong foul odor inside; a roach was observed on the floor in front of the microwave; the dining were observed to have jelly and unknown sticky substance; a hole in the wall had been cut by the floor that led from the dining to the . . . . . , and an occasional foul odor was observed to be in the dining ; a bug was observed smashed to the wall inside the dining to the door; the office had a window boarded up; the area behind the faucet in the green broken and pipes and the area inside the wall could be observed; the area where the shower head was attached to the wall was peeling; an unknown

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substance believed to be a insect was observed smashed into the living ; the blinds had a thick layer of dust; the second resident a pipe coming out of the wall and was leaking into the tub; the shower curtain in the resident a black substance that appeared to be mold. (Photos 2-22)

On at 11:20 AM an interview was conducted with Resident #2. Resident #2 stated the been treated several times for bed bugs, but Resident #2 was still experiencing itching.

On at 11:32 AM an interview was conducted with the Facility Director. She stated the pest control company has been treating specific for bed bugs, but they are not treating all of the at this time. She stated a resident with bed bugs sat in the living passed the bed bugs on to other residents. She stated the overnight staff have a list of tasks to complete each night, and they are required to fill out a sheet documenting that the cleaning tasks were completed. She stated the employee who worked last night did not fill out the sheet but told her he had completed the items. The Facility Director and surveyor chose several items from the Overnight Task Sheet at random and observed throughout the building that the items had not been completed. The Facility Director stated no one checks to see that the items have been completed. The Facility Director stated the overnight employee is supposed to wipe down the tables after breakfast before leaving, pull furniture away from the walls and sweep and mop in the main living , and dust the blinds and all furniture. She further stated the overnight employee gets off work at 8:00 AM, however, breakfast does not end until 8:15 AM, and the employee is also required to clean up the kitchen area. She stated the breakfast cook can leave prior to breakfast being over because extra plates will be made up and set out for those residents who did not arrive before 8:00 AM. The Facility Director stated there had been a plumbing problem and the hole in the dining had been cut to access the pipes behind the wall. She was not sure when it was going to be fixed. She was not able to say the last time the resident phone had been cleaned. The Facility Director also stated the microwave had been donated to the facility by an employee. The Facility Director stated she had heard that the overnight employee was staying in the office all night. (Photos 23-25)

On at 2:32 PM a record review was conducted of the pest control treatment conducted by the facility's pest control company. The report stated on #10 and #14 were treated for bed bugs, and #10 and #15 were " call back for tomorrow " for bed bug treatment. On # was found to have live bedbugs. On # was treated for bed bugs. On a note read " Retreated and 10 for bedbugs but were not prepped again. In order for correct treatment need to be done as instructed. " On #2, #10, and #14 were again treated for bed bugs.

Class II

Z827 Unlicensed Activitv

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Based on record review and interviews, the licensed facility (license 12219), located at 2135 40th Avenue North, Saint Petersburg, Florida, was found to be operating an unlicensed assisted facility at 2121 40th Avenue North, Saint Petersburg, Florida, by providing housing and meals to 4 of 4 residents (Residents #1, #2, #3 and #4) and assistance with self-administration of medication to 1 of 4 residents (Resident #2).

Findings included:

On at 7:36 AM in an interview with Resident #2, Resident #2 stated the facility provides him a pill organizer weekly with all of his medication. Resident #2 stated the staff at the assisted living facility fill the pill organizer. Resident #2 stated the medication bottles are secured in the medication the assisted living facility. Resident #2 stated his rental contract allows him to go and have meals at the assisted living facility.
On at 7:45 AM in an interview with Resident #3, Resident #3 stated his rental contract states he is allowed to go to the assisted living facility to have his meals.
On at 7:55 AM in an interview with Resident #1, Resident #1 stated her rental contract states she is allowed to have meals at the assisted living facility.
On at 8:02 AM in an interview with Resident #4, Resident #4 stated his rental contract states he is allowed to have meals at the assisted living facility.
On / at 7:50 AM in a tour of the facility it was observed the operator of the licensed facility does not live in the unlicensed location.
On in a record review of the rental contract, the contract indicated residents living in the unlicensed location have meals at the assisted living facility included in their rent payment. The residents located at the unlicensed location pay their rent directly to the assisted living facility.
On at 11:04 AM in an interview with the manager, the manager stated the medication for the residents at the unlicensed location is delivered to the assisted living facility.
On / at 11:35 in an interview with the manager, the manager stated she is responsible for placing the medication for Resident #2 in his weekly pill organizer. The manager stated Resident #2 ' s medication is secured in the medication ' the assisted living facility and not in Resident #2 ' s possession.
Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Amelia ALF
2135 40th Ave North
St. Petersburg, FL 33714

Dear Administrator :

This letter reports the findings of a complaint survey conducted , 2016 through , 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:

A0052 – Medications – Assistance with Self-Administration. **Class III.**
A0152 – Physical Plant – Safe Living Environment. **Class II.**
Z827 – Unlicensed Activity. **Unclassified.**

The facility must comply with the following:

1) The facility must have all inspected for bed bug infestation by a licensed pest control company. A report by the pest control company must document that each inspected and is either free from bed bugs or was treated. Any continuing treatment plan must be included with the documentation. This must be completed by **, 2016.**

The facility must have all broken items which were cited in the statement of deficiencies repaired by **, 2016.**

The facility must develop an on-going maintenance plan that includes the cleaning of a) the common areas, including mopping of the floors, washing the walls, resident , etc.; b) maintenance of the kitchen, to include cleaning the oven, the floors, the walls, and underneath shelving; c) maintenance of resident , including changing of the sheets, mopping of the floor, etc. This schedule must be documented and available for review by Agency personnel upon request. This must be completed by **, 2016.**

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

4) The facility must provide a copy of a satisfactory inspection by 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 **Paul Brown**, St. Petersburg Field Office, (727) 552-1955.

Sincerely,

Paul Brown
Health Facility Evaluator Supervisor