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	AL11967286	02/10/2017
NAME OF PROVIDER OR SUPPLIER **LOVING CARE OF ST PETERSBURG**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 9TH STREET NORTH** **SAINT PETERSBURG, FL 33701**	

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0000 - Initial Comments

Assisted Living Facility

On , , 2017, two complaint surveys, (CCR# 2017001143 & CCR#2017001406) were conducted at Loving Care of St. Petersburg. Deficiencies were identified at the time of the visit.

(license # 11357)

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on observation, interview, and record review, the facility failed to maintain a general awareness of the resident's whereabouts and provide supervision appropriate for the resident, resulting in the elopement of one (Resident #2) of three residents reviewed.

Findings included:

On , a review of Resident #2's chart revealed that Resident #2 had been admitted to the facility on .
On , a review of Resident #2's progress notes revealed a note dated , which stated that Resident #2 was found by the police around 7 PM on a city street. There was also a progress note dated , which stated that Resident #2 had wandered off during dinner and the police brought her back to the facility.

On , a review of Resident #2's progress notes revealed two progress notes from . The note written at 3:20 PM on stated that Resident #2 left the facility around 1:00 PM on . The note continued that another resident told facility staff that they saw Resident #2 on a city street and that the facility staff drove down that street but did not see Resident #2. The note continued that the facility filed a missing person report with the local police department for Resident #2. The note listed the specific police report number. The second progress note for was written at 9:19 PM. This progress note stated that the police came to the facility at about 7:10 PM to inform the facility staff that Resident #2 had been located at a hardware store by a family friend. The progress note also documented that Resident #2's brother had picked the resident up. The progress note stated that the police informed staff that Resident #2 had been complaining of pain and had been taken to a

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hospital by her brother.

On , a review of Resident #2's progress notes revealed two progress notes from . The progress note written at 3:17 PM on stated that Resident #2 was in the facility around 11:00 AM and had left by 11:10 AM. The progress note stated that staff looked for Resident #2 around the building but did not see Resident #2. The note stated that the local police were called and a report was made. The note listed the specific police report number. The progress note written on at 10:04 PM stated that the facility contacted local hospitals in an effort to locate Resident #2, but that they had, "no luck." The note continued that the facility left a message for Resident #2's brother to see if he had heard anything.

In an interview on at 2:15 PM, the Facility Director stated that Resident #2 left the facility at about 12:00 PM. The Facility Director stated that they contacted the police, local hospitals, and Resident #2's brother. The Facility Director stated that they had not found Resident #2 as of that time.

On at 4:38 PM, the Facility Director provided the surveyor with a completed Resident Health Assessment for Assisted Living Facilities (AHCA Form 1823) for Resident #2. A review of this AHCA Form 1823 documented that Resident #2 was at risk of elopement.

On at 5:00 PM, the Facility Director was interviewed regarding Resident #2 leaving the facility on , , , and . The Facility Director stated that Resident #2 leaving the facility was not in the facility's control. The Facility Director stated that Resident #2 did not sign out of the facility when she left the facility. The Facility Director stated that if Resident #2 was gone from the facility longer than she normally was, then they would go out and look for Resident #2. The Facility Director also stated that if they didn't see Resident #2 for a couple of hours, then the facility staff would look around the facility for Resident #2 and if they still could not locate Resident #2, then they would look for the resident outside the facility. The Facility Director was questioned in regards to what monitoring the facility provided for Resident #2. The Facility Director stated that the facility staff check on Resident #2 and that all they could do was check on Resident #2 more and look for her if they couldn't find her. During this interview, the Facility Director stated that she was notified that Resident #2 was found at a hospital.
In an interview on at 5:10 PM, the Resident Care Coordinator confirmed that the AHCA Form 1823 for Resident #2 did state that Resident #2 was an elopement risk. The Resident Care Coordinator stated that the facility was aware that Resident #2 was an elopement risk when Resident #2 was admitted to the facility. The Resident Care Coordinator was questioned as to whether any special monitoring was provided for Resident #2 due to her elopement risk status. The Resident Care

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Coordinator stated that everyone in the facility kept an eye on Resident #2 because they were aware that Resident #2 liked to "take off." The Resident Care Coordinator confirmed that the facility was not a locked or secure facility.

On at 11:30 AM, the surveyor observed the facility's resident sign out log. This log was observed in a binder next to the medication station. The log was observed to be entirely blank. There was no documentation that any resident had signed out on the log.

In an interview on at 11:35 AM, Staff F confirmed that the log observed next to the medication station was the only resident sign out log for the facility. Staff F confirmed that the resident sign out log was blank. Staff F stated that the Resident Care Coordinator may have taken the pages out of the log and that she may have them somewhere else.

In an interview on at 11:38 AM, the Resident Care Coordinator stated that the resident sign out log sheets were in the binder at the medication station. The Resident Care Coordinator also stated that the resident sign out log had been stolen recently. The Resident Care Coordinator stated she did not have an exact date of when that occurred, but estimated that the log had been stolen approximately one week ago. The Resident Care Coordinator stated that the resident sign out sheets for the past week were in the binder at the medication station. The Resident Care Coordinator did not have any additional resident sign out sheets.

In an interview on at 11:55 AM, the Facility Director confirmed that the resident sign out log for the facility was kept at the medication station. The Facility Director observed the resident sign out log with the surveyor at that time and confirmed that the log was empty and that no residents had used it to sign out of the facility. The Facility Director stated that residents were supposed to sign out on the log when they left the facility, but that only some did. The Facility Director stated that for some residents they just knew where they normally went and how long they were normally gone for. The Facility Director stated that if those residents exceeded the normal timeframes that they were gone, then the staff called and made a police report. The Facility Director stated that the facility also monitored the resident's whereabouts using headcounts at breakfast, lunch, and dinner.

On at 3:13 PM, Staff F provided the surveyor with the current week's headcount sheets. A review of the headcount sheets revealed that on Resident #2 was listed as absent at the 12:00 PM headcount. Additionally, there was no documentation as to whether or not Resident #2 was present for the 5:00 PM headcount. There was also no documentation as to whether or not an additional 48 residents listed on the headcount sheet were present for the 5:00 PM headcount. There was no documentation that the headcount for those 48 residents had been completed. There

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was also no documentation that the headcounts for at 8:00 AM and 12:00 PM had been completed for any of the residents listed on the headcount sheet. There was no documentation as to whether or not any residents listed on the sheet were present for the 8:00 AM headcount or the 12:00 PM headcount.

Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28(1-2) FS

Based on observation, record review and interview the facility failed to ensure that 1 (resident #1) of 18 residents interviewed were living in a safe and decent living environment, free from and neglect, specifically an assault on Resident #1 by a facility staff member. Additionally, the facility failed to take timely action on the allegation once the incident was reported to the facility management. The facility also failed to ensure that the telephone number for lodging complaints against the facility, the "Florida Hotline, 1(800)96- " was posted in a common area that is accessible and visible to the residents.

Findings included:

On at 1:27pm surveyors observed a video recorded via a closed circuit camera located at the facility. The video was recorded on and showed Staff #A hitting resident #1 with a plastic leg brace. Resident #1 was observed on the video recording walking quickly trying to get away from staff #A while staff #A continued to hit resident #1 from behind multiple times continuing down the hallway in the facility.

An interview was conducted with staff #C on at 3:44 PM; they stated that on , unsure of the exact time, they witnessed staff #A hitting resident #1 with a leg brace. Staff #C confirmed that staff #A did in fact hit resident #1 as they were walking away from staff #A and resident #1 had their back to staff #A when the hitting began, which continued down the hallway. Staff #C stated they called staff #H, a Resident Aide Supervisor, to alert administration of the incident. Staff #C also stated they called 911 right after the incident and the police entered the facility. Staff #C stated the police did not interview any staff nor any residents regarding the incident as at that point, they stated, "everyone was calm." Staff # C stated she informed staff #A during the incident that they should walk away. Staff #C stated they did

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not feel that Staff #A hit resident #1 in self-defense. Staff #C stated she informed the administrator and facility director on that they should watch the video filmed on .

An interview was conducted with the facility director on at 5:09 PM. The facility director stated they were not made aware of the incident between staff #A and resident #1 on the night of . The facility director stated that on staff #A told them that resident #1 jumped on her and staff #A made herself out to be the victim. The facility director stated that on as they were leaving the facility staff #C asked them if they watched the video. The facility director stated that staff #A did in fact work her normal scheduled shift the following day ( ) because they felt staff #A was the victim. The facility director stated they did watch the video on (the second day after the incident occured) and immediately took action, including calling the police, department of children and families and initiating an adverse incident report to The agency for healthcare administration (AHCA.)

An interview was conducted with the administrator via telephone on at 5:15 PM. The administrator stated that staff #C came in the office and told the administrator and the facility director to "watch the video." The administrator stated they did watch the video on around one or two PM. The administrator stated after watching the video they immediately called the police to report the from staff #A to resident #1. The administrator stated they also called the department of children and families to report the .

An attempted interview was conducted at the facility with Resident #1 at 11:22 am on . A review of Resident #1's AHCA Form 1823 during the survey indicates a diagnosis of , . The interview was discontinued as the resident was unable to respond coherently to the surveyor's questions. Resident #1 while not interviewable did not appear to have any physical injuries as a result of the assault by Staff #A. A total of 18 other residents were interviewed during the facility and none stated that they felt threatened or intimidated by Staff #A. A few of the residents indicated that they were aware of the incident between Staff #A and Resident #1.

A record review during the survey revealed that Staff #A had the required Level II Background Screening and and Neglect training in place. Staff #A was terminated on when she reported to work and subsequently placed under by local police authorities.

An observation was made during the complaint survey related to resident conducted on . It was observed that the facility posted the required resource numbers for resident to file a complaint relating to in the hallway near the administrative offices, behind a door that is kept locked by staff to prevent residents from access to office areas. There were no posters of the "Florida Hotline, 1(800)96- " observed during facility tour located in a common area for the

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residents.

During interview with the Facility Director, on at 04:01 p.m., they confirmed that the residents are not able to access the posters located near the administrative offices. The facility confirmed that the poster for the Florida Hotline was not posted in any of the residents' common area, or where the resident would be able to see the poster. They stated that they posted one in the activities , but the residents pull the poster off the wall.

Class II

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

Based on observation, interview, and record review, the facility failed to ensure that:

1. A trained staff assisted residents with self-administered medications in accordance with the procedures described in Section 429.256, F.S. for two (Resident #7 and Resident #8) of five residents observed.

2. Any concerns about suspected noncompliance were reported to the resident's health care provider and documented in the resident's record for one (Resident #2) of three residents reviewed.

Findings included:

1. On at 8:15 AM, the surveyor observed the medication technician, Staff F, assist Resident #7 with the self-administration of medication. When Staff F assisted Resident #7 with a packet of medication containing , , , , , , , and D, Staff F did not read the names of the medications from the label to the resident. Staff F did not tell Resident #7 what medications he was taking.

On at 8:20 AM, the surveyor observed Staff F assist Resident #8 with the self-administration of medication. When Staff F assisted Resident #8 in the self-administration of , , , , , , , and , Staff F did not read the names of the medications from the label to the resident. The surveyor observed Resident #8 ask Staff F, "Is that everything?" to which Staff F replied, "Yes ma'am, that's everything." Staff F did not inform Resident #8 of what medication she was being provided.

In an interview on at 9:37 AM, Staff F confirmed that reading the medication label to the

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resident was part of the required assistance with self-administration of medication process. Staff F confirmed that she did not read the medication label to Resident #7 or to Resident #8.

2. On , the medication passing detail forms for Resident #2's medications were reviewed. The review revealed that Resident #2 had refused the following medications on the following dates and times:

Aspir-Low 81mg tablet, take one tablet by mouth every day. This medication was refused by Resident #2 on: , , , and .

, 2mg tablet, take one tablet by mouth two times a day. This medication was refused by Resident #2 on: 8:00 AM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, and 8:00 PM.

10mg tablet, take one tablet by mouth two times a day. This medication was refused by Resident #2 on: 8:00 AM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, and 8:00 PM.

50mcg nasal spray, use one spray in each nostril at bedtime. This medication was refused by Resident #2 on: , and .

40mg tablet, take one tablet by mouth every day. This medication was refused by Resident #2 on: , , , and .

, 1mg tablet, take one tablet by mouth three times a day. This medication was refused by Resident #2 on: 8:00 AM, 8:00 PM, 12:00 PM, 12:00 PM, 8:00 AM, 8:00 PM, 8:00 PM, 12:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 12:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 12:00 PM, 8:00 AM, 8:00 AM,

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12:00 PM, 12:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 12:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, and 8:00 PM.

100mg tablet, take one tablet by mouth two times a day. This medication was refused by Resident #2 on: 8:00 AM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, and 8:00 PM.

ER 500mg tablet, take one table by mouth every day with largest meal. This medication was refused by Resident #2 on: , , , , , , , , , , , , and .

5mg tablet, take one tablet by mouth at bedtime. This medication was refused by Resident #2 on: , , , , , , , , , , , , , , , , , , , and .

10meq tablet, take one tablet by mouth every day. This medication was refused by Resident #2 on: and .

40mg tablet, take one tablet by mouth at bedtime. This medication was refused by Resident #2 on: , , , , , , , , , , , , , , , , , , , and .

XR 400mg tablet, take one tablet by mouth two times a day. This medication was refused by Resident #2 on: 8:00 AM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 AM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, 8:00 PM, and 8:00 PM.

B-1 100mg tablet, take one tablet by mouth every morning. This medication was refused by Resident #2 on: , , and .

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On , the facility policy titled, "Missed Medication Dose," was reviewed. This revealed that the effective date of the policy was and that the policy was that: Staff must fill out a refusal of treatment/failure to comply with medication regimen form and resident and staff must sign. If a resident refuses a , medication, they are to notify the administrator immediately. Refusal of medications will then be presented to the doctors accordingly.

On , Resident #2's medical record was reviewed and revealed that there was a refusal of treatment/failure to comply with medication regimen form for the dates of and . The form indicated that the client's medical provider had been contacted since this was the third refusal. The form documented that the medical provided who had been contacted was a nurse at Resident #2's case management organization. There were no other refusal of treatment/failure to comply with medication regimen forms in Resident #2's chart.

In an interview on at 3:38 PM, the Facility Director stated that the medication technicians are supposed to fill out a refusal form every time a resident refuses medication. The Facility Director stated that the medication technicians will notify the Administrator and the Administrator will notify the physician. The Facility Director stated that in Resident #2's case, the resident's daughter would also be notified due to a request from Resident #2's daughter to be notified of Resident #2's medication refusals. The Facility Director stated that Resident #2's refusal forms were in the progress notes in the computer and that those would be provided to the surveyor. The Facility Director clarified that the physician should be contacted for the resident when the resident has had three refusals of medications. The Facility Director also stated that the facility has not ever directly contacted Resident #2's physician. The Facility Director stated that the facility contacts the case manager for Resident #2 and the case manager contacts the physician for the facility. The Facility Director reviewed Resident #2's chart and confirmed that the only medication refusal forms in the chart were the refusals for and .

On , a review of the progress notes for Resident #2 revealed a progress note dated that stated that Resident #2 was refusing to take her medications and that her case manager and brother were made aware. The note stated that the case manager notified them that the doctor was aware. There was also a progress note dated that indicated that Resident #2's daughter came in to the facility to speak with the staff because she had received a voicemail stating that Resident #2 had refused her medication for the past three days. There were no other progress notes documenting that Resident #2's healthcare provider or family had been notified of Resident #2's other medication refusals.

Class III

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

Based on observation and interview, the facility failed to ensure that medications were kept in a locked cabinet, locked cart, or other locked storage receptacle, , or area at all times for the observed medication station.

Findings included:

On at 10:23 AM, the surveyor observed that the medication station was unattended with no staff monitoring the medication station. A staff member was observed down the hallway cleaning and medications were observed left out unsecured on the desk at the medication station. The medications were not in a locked container or area. The medication station was not in a separate locked area. The medication station was open to the hallway where residents walked. There was a chain across the opening that gave entry to behind the counter at the medication station, but there was no door blocking access to behind the medication station counter.

On at 10:25 AM, the surveyor observed the medication technician, Staff F, push a cleaning supply cart in front of medication station. Staff F spoke with a resident in front of the medication station and then went into a resident . Staff F was not in sight of the medications left out on the counter at the medication station. The surveyor was able to step over the chain across the entry way to behind the medication station counter and, at 10:27 AM, the surveyor observed the medications left out on the desk unsecured. The surveyor observed an discus and a bottle of , the generic form of , on the desk with pills observed in the bottle.

On at 10:30 AM, Staff F returned to the medication station and started to put the unsecured medications away. In an interview at that time, Staff F stated that medications were not normally left on the table and that they were normally locked up. Staff F stated that medications were supposed to be locked up. Staff F stated that she got distracted and forgot to put them away.

Class III

0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on observation, interview, and record review, the facility failed to ensure that, when there was a change in directions for the use of a medication, there was an "alert" label placed on the medication container that directed the staff to examine the revised directions for use on the medication observation

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record (MOR). This occurred for one (Resident #11) of five residents observed.

Findings included:

On at 8:44 PM, the surveyor observed the medication technician, Staff F, assist Resident #11 with the self-administration of medication. During this medication pass observation, the surveyor observed that the directions on the container of Resident #11's did not match the directions listed on the MOR for Resident #11's . The directions on the label on the medication container stated to use two sprays in each nostril at bedtime. The number two (2) had a line through it with a number one (1) written above it in pen. The directions listed on the MOR stated to use one spray in each nostril every day. There was no alert label on Resident #11's container that directed staff to examine the revised directions for use on the MOR.

In an interview on at 9:37 AM, Staff F confirmed that the directions on the medication container of Resident #11's did not match the directions listed on the MOR for Resident #11's . Staff F stated that normally an alert sticker is placed on the medication container to note the order change. Staff F confirmed that no such alert sticker was present on Resident #11's container of .

On , a review of Resident #11's physician orders revealed that on Resident #11's order was changed from two sprays in each nostril at bedtime to one spray in each nostril daily.

Class III

0084 - Training - Assis Self-Admin Meds & Med Mgmt - 58A-5.0191(5) FAC

Based on interview and record review the facility failed to ensure that 1 of 3 (#B) employee records reviewed included 2 hours of continued education for assistance with self-administration of medications and safe medication practices in an assisted living facility for unlicensed persons who provide assistance with self-administered medications and have successfully completed the initial 4-hour training.

Findings included:

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On , 2017 an employee record review was conducted for staff #B, with a hire date of . Staff #B's record included an intial 4-hour assistance with self administration of medication training dated . Staff B's record did not include a 2-hour assistance with self-administration annual update as required.

On , 2017 at 10:53 am an interview was conducted with the facility director who stated staff #B was in fact still assisting with medication self-administration and did not attend the 2-hour assistance with self-administration of medication annual update as required.

Class III

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to maintain adverse incident reports for 1 (#2) of 3 records reviewed, for an event that is reported to law enforcement or its personnel for investigation. Additionally, the facility failed to provide within 1 business day after the occurrence of an adverse incident for 1 (#1) of 3 records reviewed, a preliminary report to the agency on an adverse incident specified under this section.

Findings included:

On a record review was conducted for resident #2. Resident #2's record (progress notes) stated resident #2 eloped on . Progress notes dated stated resident #2 was last seen in the facility on around 11:00am.

An interview was conducted with the facility director on at 2:15pm. The facility director stated resident #2 left around 2pm on . The facility director stated they called the police, hospitals and resident #2's brother. The facility director stated an adverse incident report was not initiated as required within resident #2 being gone for over a 24-hour time frame.

On a record review was conducted for resident #1. Resident #1's record included a 1-day adverse incident report initiated on for an incident that occurred on .

An interview was conducted via telephone with the administrator on at 5:15pm. The administrator stated the adverse incident report was not initiated in the required 1-day, due to them not

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967286	**02/10/2017**
NAME OF PROVIDER OR SUPPLIER **LOVING CARE OF ST PETERSBURG**	STREET ADDRESS, CITY, STATE, ZIP CODE **1001 9TH STREET NORTH** **SAINT PETERSBURG, FL 33701**	

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

knowing the incident required one due to the circumstances of what they were told about the incident.

Class III