STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968024	**03/27/2017**
NAME OF PROVIDER OR SUPPLIER **BRISTOL COURT ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **3479 54TH AVE N** **SAINT PETERSBURG, FL 33714**	

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

Z814 - Background Screening Clearinghouse - 435.12(2)(b-d), FS

Based on record review and interview, the facility failed to ensure that one (Staff D) of four employee selected for record review completed the required Level 2 background screening after a gap in employment that exceeded 90 days prior to employment.

Findings included:

Review of the Clearinghouse Background Screening (BGS) employment history revealed that Staff D had a gap in employment from to . Per Employment history listed in the BGS, Staff D ' s last day of employment date was on .

Record review, conducted on , revealed that Staff D was hired by the facility on . Staff D ' s employment application (sign and dated on), did not have any dates, address, or contact information for previous employment.

Review of the BGS Clearinghouse roster revealed that Staff E was deemed eligible on .

During interview with the Activities Director, who also assist with business office when needed, and DON on at 04:00 p.m., she stated that she did not who reviewed Staff D ' s hire application. She confirmed that Staff D's employment history on the application was incomplete, and that it was not possible to determine if there was a gap in employment due to the missing of information on the application. She also confirmed that Staff D completed a level II BGS after her employment on .

Unclassified

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0000 - Initial Comments

Assisted Living Facility

On , a complaint investigation, (CCR# 2017003176), was completed at Bristol Court Assisted Living. Deficient practice was identified during the investigation.

(License # 11970)

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

Based on interview and record review, the facility did not ensure that resident privacy was protected and residents were free from in regards to the investigation and reporting of an incident of alleged resident . This occurred for one of one incidents of alleged resident involving three (Resident #1, #2, and #3) residents of the facility.

Findings included:

In an interview with the Director of Nursing (DON) on at 11:30 AM he/she provided a summary of the incident of alleged involving Resident #1, #2, and #3. The DON stated that when he/she came into work , the Business Office Manager (BOM) notified the DON that he/she had received a call from an individual, who was not affiliated with the facility, stating that a video of residents of the facility having intercourse was posted on a social media website. This individual later agreed to come to the facility and provide the DON a copy of the video. The DON stated that the video showed Resident #2 and Resident #3 having relations and the video showed a staff member wheeling Resident #1 in a wheelchair to the resident's watch Resident #2 and Resident #3 having relations. The DON stated that Resident #1 and Resident #3 were in a dating relationship and that the staff members were showing Resident #1 that Resident #3 was cheating on him/her. The DON stated that he/she immediately reported this incident to the state agency hotline.

On at 1:23 PM, Resident #3 was interviewed regarding the incident. The resident stated that he/she was having relations with Resident #2 in Resident #2's . The resident stated that he/she saw multiple staff members look in the another resident, Resident #1, look in the . Resident #3 stated that he/she was not aware at that time that he/she was recorded on video. Resident

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#3 stated that he/she did not tell any other staff members about the incident because he/she felt ashamed. Resident #3 stated he/she no longer felt safe in the facility because of the incident. Resident #3 stated that he/she felt that after the incident anything could happen to him/her in the facility. Resident #3 stated that he/she does not feel that he/she has privacy in the facility.

A review of a statement about the incident, written by the DON, revealed information that was contradictory to the DON's above statement. This statement showed that the DON was made aware of the alleged resident on . The statement documented that the DON was going to contact the state agency as of the date the statement was written, . In an interview on at 3:16 PM, the DON confirmed that he/she had written that statement. The DON confirmed the statement documented the DON was aware of the incident and that the DON contacted the state agency on . The DON stated that he/she remembered calling the state agency the same day he/she was made aware of the alleged and that there was "no way I waited two days to call DCF." The DON did not provide any additional documentation to the surveyor showing that he/she was made aware of the incident any other date beside . The DON did not provide any additional documentation to the surveyor showing that he/she notified the state agency any other date beside .

On at 3:37 PM, the state agency investigator assigned to investigate the incident was interviewed over the phone. The state agency investigator confirmed that the state agency had been notified of this incident on .

The facility did not report the alleged resident as required in Florida Statue 415.1034. Florida Statute 415.1034 includes assisted living facility staff as mandatory reporters of of adults. Any mandatory reporter who knows, or has reasonable cause to suspect, that a adult has been or is being abused is required to immediately report such knowledge or suspicion to the central hotline. None of the facility staff involved in the incident reported the alleged to the state agency hotline as required. The DON did not immediately report the alleged resident to the state agency hotline as required. There was a two-day delay in reporting the alleged resident .

A review of the undated facility policy and procedure titled, " /Neglect/ , Policy and Procedures," revealed that the facility policy was to conduct a prompt and thorough investigation of allegations of resident . The procedure outlined in this document listed that the DON was responsible for coordinating and conducting the investigation. The procedure listed that the investigation required the DON to contact the employee initiating the allegation and obtain a written statement, interview the resident, interview any witnesses or possible witnesses and obtain a written statement, and to interview the alleged , , and record the statement in writing. There was no documentation

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showing that the DON had taken these steps to investigate the alleged resident .

The DON confirmed in an interview on at 5:34 PM that there were no written statements other than the personal statement written by the DON. The DON stated that she did not fully investigate the incident because once she reported the event to law enforcement, law enforcement investigators told the DON not to interview any staff members or residents or obtain written statements.

A phone interview on at 3:43 PM with the Detective in charge of investigating the incident revealed that the law enforcement agency had been notified of the incident of alleged resident and that was when the law enforcement agency first became involved.

There was no documentation that the DON had interviewed any witnesses or residents to investigate the alleged from the date the DON became aware of the alleged , , up to the point law enforcement became involved on . There was no documentation that the facility had promptly or thoroughly investigated the alleged resident in order to reduce the potential for resident harm.

Class II

0161 - Records - Staff - 429.275(2) FS; 58A-5.024(2) FAC

Based on record review and interview, the facility failed to ensure that employment application was completed in its entirety with employment history and references furnished for one (Staff D) of four employee selected for record review.

Finding included:

Record review, conducted on , revealed that Staff D was hired by the facility on . Staff D ' s employment application (sign and dated on), did not have any dates, address, or contact information for previous employment.

During interview with the Activities Director, who also assist with business office when needed, and DON on at 04:00 p.m., She confirmed that Staff D ' s employment history on the application was incomplete, and that it was not possible to determine if there was a gap in employment due to the missing of information on the application.

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Class III