STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968203	12/08/2017
NAME OF PROVIDER OR SUPPLIER **SAINT JOSEPH ASSISTED LIVING FACILITY, INC**	STREET ADDRESS, CITY, STATE, ZIP CODE **7615 BARRY RD** **TAMPA, FL 33615**	

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

Z828 - Administrative Fines; Violations - 408.813(3) FS

Based on observation, interview and record review, that facility conducted operations while exceeding licensed capacity. Specifically, seven residents (Residents #1-7) received 24-hour assisted living services while the facility was licensed for a capacity of six residents.

Findings included:

Facility's license (#12112), effective from to , established that the facility was licensed for six beds.

During interview with Resident #2, on at 11:15 a.m., she indicated that she lives and sleeps in the facility. Observation of Resident #2's , with the Resident #2, that Resident #2 had an established her with personal belongings to include a closet of clothes, shoes and luggage (image taken).

During interview with the Administrator, on at 12:05 p.m. he stated that Resident #2 sleeps at the facility two or three nights a week and is at the facility during the day. The Administrator confirmed that the the laundry /garage belonged to Resident #2, and the clothing and belongings in the to Resident #2.

During interview with Staff D, on at 01:04 p.m., she stated that Resident #2 slept at the facility three nights a week.

During interview with Staff A, on at 02:13 p.m., she stated that Resident #2 sleeps at the facility.

During family interview for Resident #2 on , she confirmed that Resident #2 slept at the facility on the night before the survey ( ). She stated that she wanted to see how the Resident #2 tolerates living at the facility.

Unclassified

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0000 - Initial Comments

Assisted Living Facility

On , an unannounced, abbreviated, biennial state licensure survey was conducted at Saint Joseph Assisted Living, an Assisted Living Facility, located in Tampa, Florida. There were deficiencies identified at the time of the visit.

(License # 12112)

0008 - Admissions - Health Assessment - 429.26(4-6) FS; 58A-5.0181(2) FAC

Based on record review and interview, the facility failed to ensure that a resident had a face-to-face medical examination by a health care provider completed within 30 days of admission for one (Resident #2) of two residents selected for record review.

Findings included:

During interview with Resident #2, on at 11:15 a.m., she indicated that she lives and sleeps in the facility. Observation of Resident #2's that Resident #2 had a furnished , with clothing in closet.

During interview with the Administrator, on at 12:05 p.m. he stated that Resident #2 sleeps at the facility two or three nights a week, and is at the facility during the day. The Administrator confirmed that the the laundry /garage belonged to Resident #2, and the clothing, and belongings in the to Resident #2.

Class III

0010 - Admissions - Continued Residency - 429.26(1&9) FS; 58A-5.0181(4) FAC

Based on record review and interview, the facility failed to ensure that a resident had a face-to-face medical examination by a health care provider after a significant change for one (Resident #5) of two residents selected for record review; and, (2) the facility failed to ensure that a resident no longer meeting residency criteria had a comprehensive interdisciplinary plan of care with hospice, ensuring all needs of a bedridden resident (Resident #5) were met. Resident #5 was observed to require a Hoyer lift to transfer.

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Findings included:

1. Record review, conducted on , revealed, per hospice's notes, that Resident #5 was receiving hospice services that began on . Further review revealed that most recent health assessment was completed on .

Review of Resident 5's health assessment (AHCA Recommended Form 1823), dated , indicated that Resident #5 required assistance with medication.

Continued record review, on , revealed that Resident #5's hospice Service Plan for ALF Patient, dated , did not indicate what services was provided by the facility.

During interview with the Administrator, on , 03:00 p.m, the administrator confirmed that Resident #5's hospice Service Plan for ALF Patient, dated , did not indicate what the facility is supposed to do for Resident #5. He stated that he was supposed to add the services to be provided by the facility, but he never got to it.

During continued interview with the Administrator on at 03:00 p.m. he confirmed that Resident #5's health assessment, dated , was not accurate. He confirmed that a health assessment completed after Resident #5 was admitted to hospice was not available. He stated that Resident #5 currently requires medication administration.

2. During interview with Staff D, on at 01:04 p.m., she stated that the facility uses a Hoyer lift to move Resident #5.
During interview with the Hospice Nurse for Resident #5, on at 1:25 p.m., she confirmed that hospice does not use a Hoyer lift for, nor have orders for a Hoyer lift for Resident #5.

On at 2:24p.m., the Administrator, Staff C and Staff A were observed moving Resident #5. They lifted the Resident #5 from his bed; legs did not touch the ground as all three staff lifted him.
During interview with the private paid companion for Resident #5, on at 03: 11 p.m., she indicated that she and the facility employee use a Hoyer lift to move Resident #5 daily, and that it is kept in the garage (image of Hoyer lift taken).
During interview with the Administrator, on at 03:15 p.m., he confirmed that facility employees uses the Hoyer lift in the garage for Resident #5. He stated, "We use it when he is on hospice. Once again, we did not use it here because you are here. There is no order for the Hoyer lift."

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Review of Hospice Care Plane, dated , for Resident #5, which was provided by the Administrator, revealed no documentation authorizing a use of a Hoyer Lift as part of the interdisciplinary plan of care or durable medical equipment ordered for Resident #5.

Class III

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

Based on record review and interview, the facility failed to ensure that one of seven resident who resided at the facility (Resident #5) was free of .

Findings included:

On at 02:45 p.m. Staff C was observed buckling Resident #5 with a seat belt that was part of Resident #5's wheelchair.

With the Administrator present, on at 03:00 p.m., Staff C stated that she buckled the seat belt for Resident #5 when she moves him. Resident #5 was asked to unbuckle the seat belt that was fastened across his lap. Resident #5 was unable to unbuckle the belt. The Administrator stated there was no orders for the seat belt.

Class III

0053 - Medication - Administration - 58A-5.0185(4) FAC

Based on interview, and record review, the facility failed to ensure licensed staff (nurses) were available to provide medication administration to a resident (Residents #5) requiring medication administration. Specifically, unlicensed staff (Administrator) administered oral medication for Resident #5 selected for medication observation review.

Findings included:

Review of the 2017 Medication Observation Report (MOR) for Resident #5, conducted on at 12:00 p.m. revealed that two medication dosage for (12:00 p.m. and 3:00 p.m.) were documented as given by Staff C, but were not observed by surveyor who observed the 12:00p.m. medication pass. Staff C stated that a hospice nurse arrived at the facility and administered

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the medications to Resident #5.

Review of the 2017 MOR for Resident #5 revealed that Staff A, Staff C, and Staff D document that they provided the medication to Resident #5.

During interview with the Administrator and Staff C, on at 12:02 p.m., both confirmed that Staff C, who is not a licensed employee, secretly administered medication for Resident #5 so that surveyor did not see staff administer medication. The Administrator confirmed that resident #5 needs medication administration, and that unlicensed employees (Staff A, C, and D) administers medications for Resident #5.

During interview with the Hospice Nurse for Resident #5, on at 1:25 p.m., she confirmed that hospice was not administering medication to Resident #5 and that Resident #5 required medication administration.
On at 03:11 p.m., an unlicensed, paid companion, was observed administering medication to Resident #5. The paid companion, received the medication tablet that is managed by the facility from Staff C, crushed the medication, mixed it with apple sauce and spoon fed it to Resident #5. The paid companion stated that she always gives Resident #5 his 3:00 p.m. medications.

During interview with the paid companion, with the Administrator present, on at 03:54 p.m., she stated that she was not a nurse or trained to administer or assist with administering medications. She knew the name of the medication, but did not know what the side effects were or what the dosage was.

Class III

0054 - Medication - Records - 58A-5.0185(5) FAC

Based on record review and interview, the facility failed to maintain accurate and up-to-date Medication Observation Records (MORs) that reflected each time medications were provided for Resident #6, and documented medication as given for resident #5 three hours prior to the prescribed time.

Findings included:

Review of Resident #6's MOR for 2017, conducted on at 11:45 a.m., revealed that a 3:00p.m. medication dosage was documented at given. Staff C confirmed that it was her signature, and stated that it was a mistake. She did not remember when she made that documentation.

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Review of Resident #5's MOR for 2017, conducted on at12:00p.m., revealed that a 3:00p.m. medication dosage was documented as given.

During interview with the Administrator and Staff C, on at 12:02 p.m., both confirmed that Staff C made that documentation so that Agency staff did not watch Staff C administer the medication dosage. Staff C confirmed that the 3:00pm. dosage was not yet given to Resident #5.

Class III

0078 - Staffing Standards - Staff - 58A-5.019(2) FAC

Based on record review and interview, the facility failed to provide annual documentation of a negative ( ) examination for two (Staff A and Staff B) of three employees selected for record review.

Findings included:

Record review for the Administrator revealed that the last documented examination was conducted for Staff A was on ; and last examination for Staff B was on .

On , at04:30 p.m., the Administrator reviewed and confirmed that Staff A and Staff B did not have any other assessment done.
Class III