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0000 - Initial Comments

Assisted Living Facility

A Complaint Survey (CCR#: 2018018762, 2019000400, and 2019000459) in conjunction with an Extended Congregate Care Monitoring Visit and in conjunction with a Revisit to an 11/13/18 Complaint Survey (CCR#: 2018014589) was conducted at Bloom at Saint Petersburg Assisted Living Facility on 01/11/19. Bloom at Saint Petersburg Assisted Living Facility had deficient practice identified at the time of the survey.

(License#: 12498)

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

Based on record review and interview, the Facility failed to obtain complete documentation of a -to- Health Assessment with all required data for five Residents (#2, #4, #5, #6, and #8) of nine sampled residents.

Findings Included:

A review of a Health Assessment Form for Resident #2, conducted on , revealed that the resident's form, dated did not state the resident's medical diagnosis, physical or sensory status or limitations, or and behavior status or limitations. The form did not include a list of prescribed medications for Resident #2. Resident #2 was admitted to the Facility on .

A review of a health assessment for Resident #4, conducted on , revealed that the resident's form had no date of the examination. Resident #4 was admitted in to the Facility on .

A review of a health assessment for Resident #5, conducted on , revealed that the resident's form dated did not state the type of assistance that the resident required for medication administration. Resident #5 was admitted to the Facility on .

A review of a health assessment for Resident #6, conducted on , revealed that the resident's form had no date of the examination. Resident #6 was admitted to the Facility on .

A review of a health assessment for Resident #8, conducted on , revealed that the resident's form, dated did not state the type of assistance that the resident required for medication

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administration. Resident #8 was admitted to the Facility on .

During an interview with the Administrator, conducted on at 06:45pm, the Administrator acknowledged and confirmed that Residents #2, #4, #5, #6, and #8 had missing required data from their health assessments, which included resident's type of assistance needed for medication administration, a list of medications, the examination date, physical and sensory status, and and behavioral status. The Administrator stated that, "moving forward we will have appropriate documentation in place."

Class III

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

Based on record review and interview, the Facility failed to provide care and services appropriate to meet the needs of residents who were high risks and had loss. The Facility failed to contact residents' Health Care Providers and responsible Parties when the resident had a condition that required additional services.

Findings Included:

A review of the Facility's Incident Reports, conducted on , revealed that Residents #1, #3, #5, and #9 had and/or frequent .

According to record review on , Resident #1 was admitted in to the Facility on . Resident #1's most recent Health Assessment Form dated stated that the resident had diagnoses of , , , , and and that the resident required supervision with ambulation, , grooming, toileting, and transferring and assistance with bathing and was independent with eating. A record review for Resident #1, conducted on , revealed that the resident had frequent since and increased , since . Frequent unsuccessful redirection was documented in Resident #1's record. There was no documented evidence on that Resident #1's Physician was notified for one of the resident's frequent . One Risk Assessment dated found in Resident #1's record indicated that the resident was at a moderate risk for . There were no other Risk Assessments found in Resident #1's record. Resident #1 had a Care Plan dated that stated that the resident was independent with all activities of daily living, although post- documentation indicated the resident required assistance with activities of daily living due to .
Resident #1's record also indicated that the resident had a significant loss recorded in the

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resident's record. On , Resident #1 , . On , Resident #1 , . On , Resident #1 , . On , Resident #1 , .

A record review for Resident #2, conducted on , revealed that the resident made "verbal threats ...to kill everyone" on and the resident sent to the Hospital via emergency transport. There were no documented notifications to Resident #2's health care provider and Responsible Party. On , the Facility documented that Resident #2 talked "about the world ending and made other residents uncomfortable" and on , "the resident still seems ". There were no documented evidence that Resident #2's health care provider and Responsible Party were notified of the resident's change in condition. Resident #2 was admitted in to the Facility on . Resident #2's Health Assessment Form dated did not include the resident's diagnoses, physical and sensory status or and behavioral status. Resident #2's Care Plan dated did not include interventions required for the resident's condition changes.

A record review for Resident #3, conducted on , revealed that the resident had on , , , , and . There was no documented evidence that Resident #3's health care provider was notified for the that occurred on , and . There were no documented physical assessments made post- for the that occurred on , and . There were no intervention measures documented in Resident #3's record for prevention. Resident #3 was admitted in to the Facility on . Resident #3's most recent Health Assessment Form dated stated that the resident had diagnoses of , , and Gait Imbalance, required precautions, and supervision with and toileting and assistance with bathing and transferring. One Care Plan dated did not address required needs for prevention.

A record review for Resident #5, conducted on , revealed that the resident had on and . The Facility had no evidence that Resident #5's health care provider was notified related to the . There were no documented physical assessments post- for either . There were no intervention measures documented in Resident #5's record for prevention. One Risk Assessment dated documented in Resident #5's record. Resident #5 sent to the Hospital on related to a decreased , . There was no evidence that the Facility notified Resident #5's health care provider, Hospice, or Responsible Party. Resident #5 was admitted in to the Facility on . Resident #5's most recent Health Assessment Form dated stated that the resident had diagnoses of and 's , required precautions, and supervision with all activities of daily living.

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A record review for Resident #8, conducted on , revealed that the resident had a significant loss recorded in the resident's record. On /8 Resident #8's and on and , the resident , . Resident #8 was admitted in to the Facility on . Resident #8's Health Assessment Form dated stated that the resident had a diagnosis of and required supervision with eating. Resident #8's Care Plan dated did not indicate interventions implemented to meet the resident's needs for loss prevention.

A record review of Resident #9, conducted on , revealed that the resident had on , , and . The Facility had no evidence that Resident #9's health care provider was notified related to the . The Facility had no evidence that Resident #9's Responsible Party notified of the that occurred on and . There were no physical assessments documented post- for the that occurred on and . There were no intervention measures documented in Resident #9's record for prevention. Two Care Plans dated and did not address required needs for prevention. On , Resident #9 sent to the Hospital and the reason was not documented in the resident's record. There were also no documented notifications to Resident #9's health care provider or Responsible Party. Upon return to the Facility on , Resident #9 had a diagnosis of . There was no documented evidence of the precautions implemented to address the diagnosis. Resident #9 was admitted in to the Facility on . Resident #9's most recent Health Assessment Form dated stated that the resident required supervision and assistance with all activities of daily living.

During an interview with Staff G, conducted on at 11:45am, Staff G stated that the staff was unaware of any residents who frequently .

During an interview with Staff F, conducted on , Staff F stated that the staff was unaware of any residents who frequently .

A review of the Facility's Policy and Procedure, conducted on , revealed that if a resident had a that staff were to perform the Investigation Checklist which included a physical assessment and notify the resident's Physician and Responsible Party and complete a Risk Assessment as well as update the resident's Care Plan.

During an interview with the Administrator, conducted on at 06:45pm, the Administrator acknowledged and confirmed the lack of documented evidence that residents' Physician and Responsible Party were notified related to each and/or Hospital visit occurrence and that the Facility not following their Policy and Procedures. The Administrator stated that, "moving forward we will have appropriate documentation in place."

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There were no further documents provided and the Administrator unable to provide evidence of interventions put in place to meet the needs of prevention for each residents' occurrence. The Administrator was unable to provide documentation on interventions put in place to meet the needs for Residents #1 and #8's loss.
Class III

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS 429.27

Based on observation and interview the facility failed to honor residents rights by providing a clean and safe living environment.

Findings included:

A tour of the Memory Care Neighborhood conducted on beginning at 10:23am, revealed the following:

:
Both the toilet and the floor were dirty.
The towel bar was broken.

:
The toilet was dirty.
The towel bar was broken.
The shower rod was broken.

:
The bed was soiled and had a foul odor.
There were stains on the wall behind the toilet and the sink.
The towel bar was missing.
The caulk around the sink was cracked and coming away from the sink.
There were wires exposed next to the room entrance door.

During a tour of , conducted on at 1:31pm with the Director of Maintenance/Housekeeping, they acknowledged and confirmed the need for repairs and cleaning that needed to be done. The Director of Maintenance/Housekeeping stated "We need to take care of this."

During a tour of conducted on at 12:40pm with the Administrator, they acknowledged

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and confirmed that the mattress was soiled and had a foul odor. The Administrator stated "If definitely has an odor."

(photographic evidence obtained)

Class III

0052 - Medication - Assistance with Self-Admin - 429.256( ); 58A-5.0185 (3)

Based on observation and interview, the Facility failed to ensure unlicensed staff read medication labels out loud to residents and removed pills out of medication packs (original containers) as required in front of two Residents (#7 and #9) of two sampled resident that required assistance with self-administration of medications (meds).

Findings Included:

During an observation of the medication (med) pass with Staff A (an unlicensed medication technician), for Resident #7, conducted on at 11:40am, Staff A prepared Resident #7's meds in the med room which included popping the resident's prescribed med 4milligram (mg) pill from the med pack (original container) into a plastic med cup. Staff A carried the plastic med cup from the med room to Resident #7 who was sitting in the dining room. Staff A stated to Resident #7, "just take it, it's your little pill" and handed the resident the plastic med cup with the resident's medication.

At 01:15pm, Staff A prepared Resident #7's meds in the med room which included popping the resident's prescribed meds 40mg and 0.5mg from the med packs (original containers) into a plastic med cup. Staff A poured Resident #7's prescribed liquid med 45ml into a plastic med cup. Staff A carried the two plastic med cups from the med room to Resident #7 who was sitting in the activity room and stated, "I have your honey".
According to Resident #7's Health Assessment Form dated , the resident required assistance with self-administration of medication.

During an observation of the med pass with Staff A for Resident #9, conducted on at 01:20pm, Staff prepared Resident #9's meds in the med room, which included popping the resident's prescribed med Val 1 gram pill from the med pack (original container) into a plastic med cup. Staff A carried the plastic med cup from the med room to Resident #9 who was in the resident's own room and stated, "Do you want me to cut this or can you swallow it". According to Resident #9's Health Assessment Form dated , the resident required assistance with self-administration of

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medications.

During an interview with the Administrator, conducted on at 06:45pm, the Administrator acknowledged and confirmed that Medication Technicians are supposed to read the medication labels out loud to residents and supposed to pop medications out of the med packs/original containers in front of residents.

Class III

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

Based on record review, and interview, the Facility failed to employ or contract with the services of a licensed nurse to administer medications to two Residents (#5 and #6) of two sampled resident that required medication administration.

Findings Included:

A record review for Resident #5, conducted on , revealed that Resident #5's most recent Health Assessment Form dated did not stipulate the type of assistance needed for medication administration. Resident #5's record had a Health Assessment Form dated that indicated that the resident required medication administration. A review of Resident #5's and Medication Observation Records (MORs) showed that unlicensed Medication Technicians signed medications as given to the resident. Resident #5 was admitted in to the Facility on .

A record review for Resident #6, conducted on , revealed that Resident #6's undated Health Assessment Form indicated that the resident required medication administration. There were no other Health Assessment Forms in Resident #6's record. A review of Resident #5's MORs showed that unlicensed Medication Technicians signed medications as given to the resident. Resident #6 admitted in to the Facility on .

During an interview with the Administrator, conducted on , the Administrator acknowledged and confirmed that both Residents #5 and #6's Health Assessment Forms stated that both residents required medication administration; the Facility did not employ a licensed nurse to administer medications to Residents #5 and #6; and, unlicensed Medication Technicians signed medications as given to Residents #5 and #6.

Class III

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

Based on record review and interview, the Facility failed to update Medication Records (MORs) each time medications (meds) were offered to five Residents (#1, #3, #4, #6, and #9) of six sampled residents who required assistance with meds or medication administration.

Findings Included:

A review of Resident #1's MORs, conducted on , revealed that the residents MORs had meds not documented as given to the resident. On Resident #1's MORs, the following meds were not documented as given to the resident:
- 20mg not documented as given on at 05:00pm
- Levetiraceta 500mg not documented as given on at 05:00pm
There were no explanations documented on Resident #1's MORs as to the reason that the meds not given to the resident. There were no orders to hold the meds in Resident #1's record. Resident #1 admitted in to the Facility on and discharged on . According to Resident #1's Health Assessment Form dated , the resident required assistance with self-administration of medications.

A review of Resident #3's MORs, conducted on , revealed that the resident's MORs had meds not documented as given to the resident. On Resident #3's MORs, the following meds were not documented as given to the resident:
- / , 25-100mg not documented as given on , , and at 06:00pm
- 3.125mg not documented as given on at 05:00pm
- 50mg not documented as given on at 05:00pm
There were no explanations documented on Resident #3's MORs as to the reason that the meds not given to the resident. There were no orders to hold the meds in Resident #3's record. Resident #3 was admitted in to the Facility on . According to Resident #3's Health Assessment Form dated , the resident required assistance with self-administration of meds.

A review of Resident #4's MORs, conducted on , revealed that the resident's MORs had meds not documented as given to the resident. On Resident #4's MORs, the following med not documented as given to the resident:
- , 5mg not documented as given on and at 06:30pm
There were no explanations documented on Resident #4's MORs as to the reason that the meds not given to the resident. There were no orders to hold the meds in Resident #4's record. Resident #4 was

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admitted in to the Facility on . According to Resident #4's undated Health Assessment Form, the resident required assistance with self-administration of meds.

A review of Resident #6's MORs, conducted on , revealed that the resident's MORs had meds not documented as given to the resident. On Resident #6's, MORs, the following meds not documented as given to the resident:
- Orange Powder not documented as given on at 05:00pm
- 40mg not documented as given on at 09:00pm

There was no explanations documented on Resident #6's MORs as to the reason that the meds not given to the resident. There were no orders to hold the meds in Resident #6's record. Resident #6 was admitted in to the Facility on . According to Resident #6's undated Health Assessment Form, the resident required medication administration.

A review of Resident #9's MORs, conducted on , revealed that the resident's MORs had meds not documented as given to the resident. On Resident #9's, MORs, the following meds not documented as given to the resident:
- 2.5mg not documented as given on at 05:00pm
- 100mg not documented as given on at 05:00pm
- 100mg not documented as given on at 05;00pm
- 1% Gel not documented as given on at 09:00pm; at 05:00pm

There were no explanations documented on Resident #9's MORs as to the reason that the meds not given to the resident. There were no orders to hold the meds in Resident #9's record. Resident #9 was admitted in to the Facility on . According to Resident #9's Health Assessment Form dated , the resident required assistance with self-administration of meds.

During an interview with the Administrator, conducted on at 06:45pm, the Administrator acknowledged and confirmed that Residents #1, #3, #4, #6, and #9 had meds not documented as given on their MORs. The Administrator stated that, "moving forward we will have appropriate documentation in place."

Class III

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

Based on record review and interview, the Facility failed to ensure that medications (meds) were filled or refilled in a timely manner for three Residents (#1, #5, and #9) of six sampled residents who required

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assistance with self-administration of medications or medication administration.

Findings Included:

A review of MORs for Resident #1, conducted on , revealed that the resident had prescribed meds not given due to "med not in cart". Resident #1's meds not available on the resident's MORs included:

- 3mg circled as not given from through at 08:00pm

The reasons explained on Resident #1's MORs that the resident's meds were not given were that the "meds not in cart". There was no evidence in Resident #1's record that the resident's health care provider was notified that the resident was not receiving the prescribed medications for nine days. There was no evidence found in Resident #1's record that the Facility made a reasonable effort to obtain the resident's prescribed meds. There were no health care provider orders found in Resident #1's record to hold the prescribed meds until available. According to Resident #1's Health Assessment Form dated , the resident required assistance with self-administration of medications.

A review of Medication Observation Records (MORs) for Resident #5's, conducted on , revealed that the resident had prescribed meds not given due to "med not in cart". Resident #5's meds not available on the Resident's MORs included:

- 400mg circled as not given on , , , , , , , , , , , , , , , , , and
- Solution circled as not given on , , , and
- 25-100mg circled as not given on
- circled as not given on , , , , , , , , and
- circled as not given on , , , , , , , and
- 2.5mg circled as not given on and

Resident #5's meds not available on the MORs included:

- 400mg circled as not given from through
- 40mg circled as not given from through

The reason explained on Resident #5's and MORS that the resident's meds were not given was that the "meds not in cart". There was no evidence in Resident #5's record that the resident's health care provider was notified that the resident was not receiving the prescribed meds. There was no evidence found in the Resident #5's record that the Facility made a reasonable effort to obtain the resident's prescribed meds. There were no health care provider orders found in

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Resident #5's record to hold the prescribed meds until available. According to Resident #5's Health Assessment Form dated , the resident required medication administration.

A review of MORs for Resident #9, conducted on , revealed that the resident had prescribed meds not given due to "med not in cart". Resident #9's meds not available on the resident's MORs included:
- , 40mg circled as not given on
- 4mg circled as not given on , , and
- , 0.3% , Solution circled as not given on and
- circled as not given on , , and

The reasons explained on Resident #9's MORs was that the resident's meds not given were that the "meds not in cart". There was no evidence in Resident #9's record that the resident's health care provider was notified that the resident was not receiving the prescribed meds. There was no evidence found in the Resident #9's record that the Facility made a reasonable effort to obtain the resident's prescribed meds. There were no health care provider orders found in Resident #9's record to hold the prescribed meds until available. According to Resident #9's Health Assessment Form dated , the resident required assistance with self-administration of medications.

During an interview with the Administrator, conducted on at 06:45pm, the Administrator acknowledged and confirmed that Residents #1, #5, and #9 had meds not given due to the unavailability of the meds and no documented evidence that the residents' health care providers were notified of the residents not receiving their prescribed meds. The Administrator stated that, "moving forward we will have appropriate documentation in place."

Class III

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

Based on record review and interview the facility failed to ensure 3 of 3 (Staff B, C and D) employees whose records were reviewed included written documentation from a health care provider stating they are free of communicable within 6 months prior to hire or within 30 days of hire.

Findings included:

A record review was conducted for Staff B on , with a hire date of Staff B's record did not included written documentation from a health care provider stating they are free of communicable

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with in 6 months prior to hire or within 30 days of hire.

A record review was conducted for Staff C on , with a hire date of Staff C's record did not included written documentation from a health care provider stating they are free of communicable with in 6 months prior to hire or within 30 days of hire.

A record review was conducted for Staff D on , with a hire date of Staff D's record did not included written documentation from a health care provider stating they are free of communicable with in 6 months prior to hire or within 30 days of hire.

During an interview conducted on at 2:11pm, the Business Office Manager acknowledged and confirmed the lack of documentation from a health care provider stating Staff B , C and D are free from communicable within 6 months prior to hire or within 30 days of hire. The Business Office Manager stated "We don't have the communicable statement."

Class III

0093 - Food Service - Dietary Standards - 58A-5.020(2) FAC

Based on observation and interview the facility failed to post the dining menu in a conspicuous place and failed to inform the residents of substitutions to the menu before or when the meal was served.

Findings included:

A tour of the Memory Care Neighborhood conducted on at 10:23am, revealed that no menu was posted in the Memory Care Neighborhood.

During an interview conducted on at 11:35am, Staff F acknowledged and confirmed that there was no menu posted in the Memory Care Neighborhood. Staff F stated " There's no menu posted in Memory Care."

During an interview conducted on at 11:55am, the Dining Services Manager acknowledged and confirmed that there was no menu posted in the Memory Care Neighborhood. The Dining Services Manager stated "Absolutely there should be a menu in Memory Care."

During an interview conducted on at 12:41pm, the Administrator acknowledged and confirmed

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that there was no menu posted in the Memory Care Neighborhood. The Administrator stated "Yes they should have one in Memory Care too."

An observation of the lunch meal conducted on at 11:21am, revealed that the meal served was chicken, rice, vegetable, salad and cake, however a review of the menu for Friday revealed the meal should have been crunch-topped fish or ham and gravy, savory Mexican rice, green bean Almondine, green salad and orange cake.

During an interview conducted on at 11:55am, the Dining Services Manager acknowledged and confirmed that the residents were not made aware of the change in the menu prior to the meal being served or when the meal was being served. The Dining Services Manager stated "I didn't post or make the residents aware of the menu changes before the meal was served."

Class III

0160 - Records - Facility - 58A-5.024(1) FAC

Based on record review and interview, the Facility failed to maintain an up-to-date Admission and Discharge Log, which included residents' resident place of admission and discharge and reason for discharge.

Finding included:

A review of the Facility's Admission and Discharge Log, conducted on , revealed that the Facility did not log where residents were admitted from or discharged to and the reason residents were discharged. There were no entries for residents admitted after .

During an interview with the Administrator, conducted on at 12:05pm, the Administrator stated that the Admission and Discharge Log had been this way since the Administrator's date of hire and that there were no other logs. At 06:45pm, the Administrator acknowledged and confirmed that the Facility's Admission and Discharge Log did not contain all required data and there were no entries made after .

Class III