| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11965303** | **02/19/2019** |
| NAME OF PROVIDER OR SUPPLIER<br>**ALBINA MANOR** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**820 15 TH STREET N.**<br>**SAINT PETERSBURG, FL 33705** | |

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

**0000 - Initial Comments**

Assisted Living Facility

A complaint investigation (CCR 2019001935) was conducted at Albina Manor on . . . . Albina Manor had deficiencies at the time of the investigation.

(License #9774)

**0007 - Admissions - Criteria - 429.26(11) FS; 58A-5.0181(1) FAC**

Based on record review and interview, the Facility failed to ensure the appropriateness of residency for two Residents (#1 and #2) of two residents sampled who did not meet admissions criteria.

Findings Included:

A record review for Resident #1, conducted on , revealed that Resident #2's re-admission's Health Assessment Form dated stated that the resident's "needs cannot be met in and ALF (Assisted Living Facility)" and that the resident required medication administration.

A record review for Resident #2, conducted on . . . . , revealed that Resident #2's admission's Health Assessment Form dated stated that the resident's "needs cannot be met in an ALF (Assisted Living Facility)", Resident #2 required 24-hour nursing or , . . . . care, and the resident required medication administration.

During an interview with the Administrator, conducted on at 01:05pm, the Administrator acknowledged and confirmed that Resident #1 and #2 were inappropriate for admissions in to the Facility, as both residents did not meet admissions criteria according to their Health Assessment Forms. At 01:45pm, the Administrator confirmed that the Facility did not employ or contract with a licensed nurse to meet the needs of Resident #1 and #2's required medication administration.
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 supervise residents and provide care and services to meet the needs of the residents, including maintaining a general awareness of health, safety, and physical and emotional well-being of one of one sampled residents (Resident #1). This

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placed the resident at risk, due to the resident leaving the facility without staff or responsible party being aware of Resident #1's whereabouts and the resident missing from the facility until the following day. In addition, the Facility failed to maintain a written record for residents updated with changes in condition, illnesses, hospitalizations, and elopements for two Residents (#1 and #2) of four residents sampled.

Findings Included:

A review of a law enforcemnt report for Resident #1, conducted on , revealed that Staff C reported Resident #1 as missing from the Facility on at 07:32pm and indicated the resident had been missing since 06:40pm. Staff C reported to law enforcement that Resident #1 had been missing from the Facility before (no date or time noted). Staff C stated that the last time staff observed Resident #1 was at 06:40pm on "in the common dining area". At 07:15pm, Staff C was reportedly "preparing to distribute nighttime medications and unable to locate [Resident #1]". Staff C told Police Officers that the Facility searched and when unable to locate Resident #1, the staff contacted the police. Resident #1 was found on twenty blocks away from the Facility.

During an observation, conducted during survey on at 11:45am, the Administrator of the facility showed Surveyors a dated and time-stamped still photograph which showed Resident #1 exiting the front door of the Facility on at 05:38pm (contradictory to the time frame documented in the law enforcement report.)

A record review for Resident #1, conducted on , revealed that Resident #1 was admitted in to the Facility on . Resident #1's Health Assessment Form dated stated that the resident required medication administration, was an elopement risk, and had a diagnosis of and was forgetful and required assistance with bathing, , grooming, and toileting. Resident #1's Health Assessment Form also stated that the resident's "needs cannot be met in an ALF (Assisted Living Facility)". Resident #1 required daily oversight for wellbeing, whereabouts, and reminders for important tasks. There were no services listed on page five that the Facility offered or arranged to meet Resident #1's required care needs. Resident #1's contract indicated that the resident paid an additional $100.00 per month for personal care services which included medication supervision and assistance with ambulation and transferring.

A review of a local Hospital's Discharge Report reavealed that Resident #1 was admitted in to the Hospital involuntarily due to behavioral disturbances on . Resident #1 was discharged from the Hospital to the Facility on .

Resident #1's record had documentation from the Behavioral Hospital's involuntary admission under a

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from the Facility on . The Facility had no documentation in Resident #1's record that included events that led up to Resident #1's . There were no documented notifications to Resident #1's Power of Attorney/Responsible Party. Resident #1 returned to the Facility on . The Certificate of Professional Involuntary Examination Form dated signed by Resident #1's Advanced Practice Registered Nurse (ARNP) stated that the resident had a diagnosis of and 's and that the involuntary admission/ was due to the resident's non-compliance with medications and that the resident's mental health deteriorated. The ARNP stated that, "patient has been med (medication) non-compliant last few weeks causing decompensation in his mental health. Yesterday, broke door and room furniture related to - today tried to climb fence to 'get away from the aliens' not redirectable posing threat to one's safety". There was no documentation in Resident #1's record related to the resident's medication non-compliance or agitated or aggressive behaviors.

Resident #1's record had a Progress Note dated signed by the resident's ARNP related to Resident #1's medication non-compliance and noted medication changes. On , the ARNP noted Resident #1's bizarre and indicated the resident was resistive to Activities of Daily Living. On , the ARNP noted that Resident #1 had "increased issues" and was "resistive to care, , and somewhat appearing". On , the ARNP noted recent hospitalization with no date given.

Resident #1 had a total of two notations made by the Facility in the resident's record. On , staff noted that Resident #1 was "behaving aggressively" and that the ARNP was notified and made medication changes. On , staff noted that Resident #1 went missing from the Facility at approximately 02:00pm and the Police were notified and brought the resident around 10:20 (no am or pm or date noted). There was no additional documentation in Resident #1's record to identify care and service needs that Resident #1 required or interventions or prevention measures identified in Resident #1's record to meet the resident's required care needs or behavioral needs. The Facility did not update Resident #1's record to include changes in condition, illnesses, behavioral issues (agitation and aggression). Resident #1's Medication Observation Records were signed by the Facility's Medication Technicians/unlicensed staff from through when the resident required medication administration. Resident #1's Medication Observation Records did not include any refusals of any medication that corresponded with the ARNP's notes about non-compliance but instead had all medications during that timeframe documented as given.

A phone interview was conducted with the power of attorney (POA) for Resident #1 on at 12:39 PM. The POA stated that Resident #1 was reported missing on at 5:30 PM and the POA found out about the elopement by watching the news on television. The POA stated that the Administrator did

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not inform them until at 7:15 AM when a voicemail message was left. The POA stated that the Facility never informed them about Resident #1's previous elopements, and the POA found out about these elopements when meeting with the local police. The POA also stated that, upon Resident #1's admission to the Facility, the Administrator assured the POA that Resident #1 would be monitored and wouldn't be able to leave the Facility.

During an interview with Staff A, conducted on at 10:10am, Staff A stated that residents were able to "come and go as they please unless family tells us otherwise".

A record review for Resident #2, conducted on , revealed that Resident #2 was admitted in to the Facility on . Resident #2's Health Assessment Form dated indicated that the resident required medication administration, precaution which included "wears a helmet", 24-hour nursing or , care, and "needs cannot be met in an ALF (Assisted Living Facility)". Resident #2 required daily oversight for wellbeing, whereabouts, and reminders for important tasks. There were no services listed on page five that the Facility offered or arranged to meet the resident's care needs. Resident #2's Health Assessment form did not include an elopement risk assessment. There was no documentation in Resident #2's record, which identified interventions for the resident's identified need of precautions other than the helmet identified on the resident's Health Assessment Form.

During an observation of Resident #2, conducted on at 01:00pm, Resident #2 was observed not wearing a helmet ordered for precautions while in the dining room.

During an interview with the Administrator, conducted on at 10:15am, the Administrator stated that Resident #1 was not an elopement risk . The Administrator stated that the resident left the Facility on two occasions that led to notification to law enforcement and law enforcement conducted an area search but stated that Facility residents, "unless , , they can come and go as they please". The Administrator stated that no residents that resided in the Facility were elopement risks. Resident #1 could come and go because the resident was not an elopement risk. The Administrator stated that Resident #1 was "unpredictable and if you walk up on him and touch him [the resident] will hit/swing at you". It was for Resident #1's unpredictability that the Facility called law enforcement versus an elopement. At 01:00pm, the Administrator stated that Resident #2 only wore the ordered helmet when the resident left the Facility. The Administrator failed to provide health care provider orders or documentation by the end of survey that indicated Resident #2 did not have to wear the helmet at all times.

Class II

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**0032 - Resident Care - Elopement Standards - 58A-5.0182(8) FAC; 429.41(1)(a)3 & 3.(l)**

Based on observation, record review and interview, the facility failed to maintain detailed facility resident elopement response policies and procedures (Elopement Policy and Procedures) that included identification of specific staff responsible for implementation. Additionally, the facility failed to conduct and document resident elopement drills as required under Section 429.41(1)(a)3 and Section 429.41(1)(l), Florida Statutes.

Findings included:

A review of the facility's Elopement Policy and Procedures entitled Elopement Report Policy and Procedure (not dated) revealed that no specific staff were identified as to who was responsible for implementing the plan in the event of a resident elopement (photographic evidence obtained).

The Administrator was asked to provide copies of the facility's resident elopement drill log at 1:24 PM on . At 1:27 PM, the Administrator was observed holding a piece of paper and correction fluid. The Administrator was asked what they were doing and there was no response. The Administrator was then asked to show the document they were holding and it was documentation of an elopement response drill exercise dated " /1" with evidence that the "2" (of year 2012) was whited out (photographic evidence obtained). The administrator stated that the date of the document was and acknowledged that documentation of the most recent facility elopement drill was .

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 (#1 and #2) of two sampled resident that required medication administration.

Findings Included:

A record review for Resident #1, conducted on , revealed that Resident #1's Health Assessment Form dated stated that the resident required medication administration. Resident #1's Medication Observation Records for , , , , and (See Photographic Evidence4) had all medications for the resident signed as given by the Facility's Medication Technicians which included the Administrator and Staff A, B, C, and E.

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A record review for Resident #2, conducted on [redacted], revealed that Resident #2's Health Assessment Form dated stated that the resident required medication administration. Resident #2's Medication Observation Records for [redacted], and [redacted] (See Photographic Evidence3) had all medications for the resident signed as given by the Facility's Medication Technicians (unlicensed staff) which included the Administrator and Staffs A, B, C, and E.

During an interview with the Administrator, conducted on [redacted] at 01:45pm, the Administrator acknowledged and confirmed that both Resident #1 and #2's Health Assessment Forms stated that both residents required medication administration. The Administrator stated that the Facility did not hire licensed nurses or contract with a licensed nurse to provide medication administration that Resident #1 and #2 required per their Health Assessments.

Class III

**0162 - Records - Resident - 58A-5.024(3) FAC**

Based on record review and interview, the facility failed to maintain documentation of a resident's power of attorney (POA), for one (Resident #1) of one record reviewed for documentation of a POA.

Findings included:

A review of Resident #1's record, conducted on [redacted], revealed no legal documentation issued for their POA.

A review of Resident #1's record revealed documentation from the resident's managed care company that the POA was responsible for assisting the resident with medical and financial decisions (photographic evidence obtained).

A phone interview was conducted with Resident #1's POA on [redacted] at 12:39 PM and the POA stated that they provided the facility with the POA documentation nine months ago. Subsequently, the POA sent the surveyor a copy of the POA document that was dated [redacted] (photographic evidence obtained).

An interview was conducted with the Administrator at 2:05 PM on [redacted]. They were asked to show the POA documentation for Resident #1 and they said, "I don't have it."

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Class III

**0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23( & ) FS; 58A-5.0241 FAC**

Based on record review and interview, the facility failed to file an adverse incident report, for an elopement that was reported to local law enforcement, in which the elopement placed the resident at risk for harm for one (Resident #1) of one resident sampled.

Findings included:

An interview was conducted with the Administrator at 11:45 AM on and the Administrato showed a video (time stamped 5:38 PM on ) of Resident #1 leaving the premises through the front door. The Administrator stated that the local authorities were contacted at 6:45 PM as Resident #1 was not at the facility when a staff member was ready to provide them with their evening medications.

The local authorities notified the news media and conducted a search for Resident #1. According to a report from the local authorities dated , Resident #1 was found under a bridge and was brought to a local hospital. Resident #1's condition at that time was described as , , and was also described as "dirty."

An interview was conducted with the Administrator at 10:18 AM on and the Administrator stated that if you walk up to Resident #1 and touch them, they "will hit/swing at you." The Administrator stated that they called the police because of this behavior. The Administrator described the resident's behavior as "unpredictable".

A review of Resident #1's health assessment dated revealed that the resident required assistance with medication administration, verbal cues with bathing and grooming, and special precautions to prevent . A review of the medication list revealed that the resident was prescribed an medication which was required to be provided during the evening, at the time Resident #1 eloped from the facility.

A review of Resident #1's record also revealed documentation dated that the resident walked out of the facility at around 2:00 PM and the police returned them to the facility at 10:20 PM (photographic evidence obtained).

The Administrator was interviewed at 10:18 AM concerning Resident #1's elopement on . They were asked to show proof of filing an adverse incident report and they stated that they had not done so.

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Review of the Agency's internal incident reporting system on _____ revealed no adverse incident report file regarding an elopement of Resident #1 from the facility.

Class III