Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965303	A. BUILDING: _____ B. WING _____	08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBINA MANOR	820 15 TH STREET N. SAINT PETERSBURG, FL 33705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint number 2019012337) was conducted at Albina Manor (Assisted Living Facility) on . Deficiencies were identified at the time of the survey.	A 000		
A 010 SS=D	429.26(1&9) FS; 58A-5.0181(4) FAC Admissions - Continued Residency 429.26 (1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination shall be based upon an assessment of the strengths, needs, and preferences of the resident, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department. (9) A , ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a	A 010		

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A 010	Continued From page 1 physician who agrees that the physical needs of the resident are being met. 58A-5.0181 (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (c) of this subsection, criteria for continued residency in any licensed facility must be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a [illegible]-to-[illegible] medical examination by a health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule and must be completed in accordance with that paragraph. Exceptions to the requirement to meet the criteria for continued residency are: (a) The resident may be bedridden for no more than 7 consecutive days. (b) A resident requiring care of a [illegible] may be retained provided that: 1. The resident contracts directly with a licensed home health agency or a nurse to provide care, or the facility has a limited nursing services license and services are provided pursuant to a plan of care issued by a health care provider, 2. The condition is documented in the resident's record; and, 3. If the resident's condition fails to improve within 30 days, as documented by a health care provider, the resident must be discharged from the facility. (c) A [illegible] ill resident who no longer meets the criteria for continued residency may continue	A 010		

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A 010	Continued From page 2 to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to receive services from a licensed hospice that coordinates and ensures the provision of any additional care and services that the resident may need; 2. Both the resident, or the resident's legal representative if applicable, and the facility agree to continued residency; 3. A licensed hospice, in consultation with the facility, develops and implements a interdisciplinary care plan that specifies the services being provided by hospice and those being provided by the facility; and, 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The facility administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility at all times. (e) A hospice resident that meets the qualifications of continued residency pursuant to this subsection may only receive services from the assisted living facility's staff which are within the scope of the facility's license. (f) Assisted living facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living for residents admitted to hospice; however, staff may not exceed the scope of their professional licensure or training. (g) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility retained a resident (#3) who exceeded the continued residency criteria in an Assisted Living Facility (ALF).	A 010		

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A 010	Continued From page 3 Findings included: Review of the facility's posted license revealed that the facility held a standard license. A record review for Resident #3 revealed a facility admission date of and a Health Assessment Form (1823) dated that indicated that Resident #3 required 24-hour nursing or care. During an interview conducted on at 6:59am, the Administrator confirmed that Resident #3's 1823 dated indicated that Resident #3 required 24-hour nursing or care. The Administrator stated "I didn't know it said that." (photographic evidence obtained) Class III	A 010		
A 025 SS=J	429.26(7) FS; 58A-5.0182(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.	A 025		

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A 025	Continued From page 4 58A-5.0182 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure they had sufficient staff to provide care, services and oversight to ensure the safety and well-being of all 15 residents of the facility (Residents #1-#15). Additionally, the facility failed to provide supervision for residents that required	A 025		

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A 025	Continued From page 5 assistance with transfers, ambulation, and toileting and placed all residents in immediate danger by leaving the residents alone resulting in 1 (Resident #1) of 15 residents being sent to the emergency room due to not being provided with the required care and services to meet their needs. Findings included: A record review conducted on . . . . for Staff A revealed she was hired as a Medication Technician/Resident Aid with a hire date of . Staff A was scheduled to work from 10:00pm on . . . . to 8:00am on . . . . and at that time Staff A was the only staff scheduled to work at the facility. A review of the facility's surveillance camera photo still shot conducted on revealed Staff A exiting the facility at approximately 11:25pm on . During an interview conducted on 5:15am, Staff B confirmed that Staff A had left the facility and the residents were unsupervised. Staff B stated "she (Staff A) left the facility without letting anyone know and didn't call anyone." "A resident called me and said no one was at the facility." During an interview conducted on . . . . at 7:23am, Resident #6 confirmed that Staff A had left the facility and the residents were unsupervised. Resident #6 stated "She (Staff A) left the facility and the police came." Record review of the residents' Health Assessment Form (1823) conducted on revealed 5 residents required assistance with transfers, 6 residents required assistance with	A 025		

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A 025	Continued From page 6 ambulation, 3 residents requires assistance with toileting, and all 15 residents required assistance with self-administration of medications. During an interview conducted on [redacted] at 7:26am, Resident #1 confirmed that Staff A had left the facility and the residents were unsupervised. Resident #1 stated "Yeah, she (Staff A) wasn't here." During an interview conducted on [redacted] at 8:12am, Resident #2 confirmed that Staff A had left the facility and the residents were unsupervised. Resident #2 stated "I was the one that called the paramedics for my roommate (Resident #1) who was sick and had severe [redacted] and I couldn't find staff (Staff A)." She (Staff A) went out 10:00pm-4:00am." A record review conducted on [redacted] of the Law Enforcement report, dated [redacted], revealed that the facility called 911 around 2:29am and when Law Enforcement arrived at the facility at 2:34am no staff was observed. Staff A returned to the facility at approximately 3:00am and was questioned by Law Enforcement. Staff A admitted to leaving the facility and going to a social club before returning to work. Staff A also admitted she knew the patients would be left unattended and not cared for, however she did not think it to be "a big deal." A record review of Resident #1's Health Assessment Form (1823) dated [redacted] revealed that Resident #1 was diagnosed with [redacted], difficulty walking, [redacted] (no behaviors), bi-polar [redacted], and [redacted], Resident #1 required a walker or wheeling self in the	A 025		

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A 025	Continued From page 7 wheelchair for ambulation, assistance with toileting and assistance with self-administration of medications. (photographic evidence obtained) A record review conducted on of the Law Enforcement report dated revealed that Resident #1 was covered in feces from her waist down, feces covered the lower portion of her bed and feces was on the floor. A record review conducted on of Emergency Medical Services ( ) Patient Care Report dated revealed that arrived at the facility and that Resident #1 stated she woke up with . She stated she was unable to control her and started to defecate on her bed. Resident #1 stated her and the floor were covered in feces and she was afraid of walking to the bathroom so she would not . She was transported to the local hospital on at 2:23am. (photographic evidence obtained) A record review conducted on of the Emergency Room Report dated revealed the following note: "Okay to discharge seems like the only reason that patient came here is because no one could help (Resident #1) clean herself". A record review conducted on for Resident #1 revealed no documentation of an incident report being completed, health care provider, family or Power of Attorney being notified or intervention to prevent further incidents. A record review of Resident #2's Health Assessment Form (1823) dated revealed that Resident #2 was diagnosed with	A 025		

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A 025	Continued From page 8 /reactive airway , myelopathy, post- stress , right humoral . Resident #2 required assistance with self-administration of medications. (photographic evidence obtained) A record review conducted on of the Law Enforcement report dated revealed that (Resident #2) suffered emotional harm due to the experience being so for her. A record review conducted on for Resident #2 revealed no documentation of an incident report being completed, health care provider, family or Power of attorney being notified or intervention to prevent further incidents. During an interview with the Administrator on at 7:04am. The Administrator confirmed the lack of documentation of incident reports for Resident #1 or Resident #2. She stated "I didn't do one". During an interview conducted on at 6:50am, the Administrator confirmed that Staff A had left the facility and the residents unsupervised. The Administrator stated "she (Staff A) left the facility without notification and around 2:30am supervisor called me and I came here and police was here." The administrator also stated "she should have called me and made sure the residents were safe". Class I	A 025		
A 165 SS=D	429.23(&) FS; 58A-5.0241 FAC Risk Mgmt & QA; Adverse Incident Report	A 165		

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A 165	Continued From page 9 429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.- (1) Every facility licensed under this part may, as part of its administrative functions, voluntarily establish a risk management and quality assurance program, the purpose of which is to assess resident care practices, facility incident reports, deficiencies cited by the agency, adverse incident reports, and resident grievances and develop plans of action to correct and respond quickly to identify quality differences. (2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term, "adverse incident" means: (a) An event over which facility personnel could exercise control rather than as a result of the resident's condition and results in: 1. ; 2. or damage; 3. Permanent ; 4. or of bones or joints; 5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives; 6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident ' s condition before the incident; or 7. An event that is reported to law enforcement or its personnel for investigation; or (b) Resident elopement, if the elopement places the resident at risk of harm or injury. (3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, by electronic mail, facsimile, or United	A 165		

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A 165	Continued From page 10 States mail, a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident. (4) Licensed facilities shall provide within 15 days, by electronic mail, facsimile, or United States mail, a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident. (6) [illegible], neglect, or [illegible] must be reported to the Department of Children and Families as required under chapter 415. (7) The information reported to the agency pursuant to subsection (3) which relates to persons licensed under chapter 458, chapter 459, chapter 461, chapter 464, or chapter 465 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 apply. (8) If the agency, through its receipt of the adverse incident reports prescribed in this part or through any investigation, has reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate board, the agency shall report this fact to such regulatory board.	A 165		

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A 165	Continued From page 11 (9) The adverse incident reports and preliminary adverse incident reports required under this section are confidential as provided by law and are not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or appropriate regulatory board. (10) The Department of Elderly Affairs may adopt rules necessary to administer this section. 58A-5.0241 Adverse Incident Report. (1) INITIAL ADVERSE INCIDENT REPORT. The preliminary adverse incident report required by Section 429.23(3), F.S., must be submitted within 1 business day after the incident pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. (2) FULL ADVERSE INCIDENT REPORT. For each adverse incident reported in subsection (1) above, the facility must submit a full report within 15 days of the incident. The full report must be submitted pursuant to Rule 59A-35.110, F.A.C., which requires online reporting. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to complete an Adverse Incident Report with the Agency for Health Care Administration (AHCA) following an incident that resulted in a resident (Resident #1) being transported to the hospital and Law Enforcement being called to the facility. Findings included: A record review conducted on of the Law Enforcement report dated revealed that the facility called 911 around 2:29am and when Law Enforcement arrived at the facility at 2:34am no staff was observed. Staff A returned to the	A 165		

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A 165	Continued From page 12 facility at approximately 3:00am at which time Staff A was questioned by Law Enforcement. Staff A admitted to leaving the facility and going to a social club before returning to work. Staff A also admitted she knew the patients would be left unattended and not cared for, however she did not think it to be "a big deal". A record review of the Facility's Adverse Incident Reports revealed no documentation that the facility had completed and Adverse Incident Report with the Agency for Health Care Administration (AHCA) following an incident that resulted in a resident (Resident #1) being transported to the hospital and Law Enforcement being called to the facility. During an interview conducted on at 7:05am, the Administration confirmed that they had not completed and Adverse Incident Report with the Agency for Health Care Administration (AHCA) following an incident that resulted in a resident (Resident #1) being transported to the hospital and Law Enforcement being called to the facility. The Administrator stated "I didn't know that I should do one." Class III	A 165		