

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969774</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/25/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANNIES AT CAPEBEND LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2011 CAPE BEND AVE<br/>TAMPA, FL 33613</b>                                   |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| CZ814                                                             | <p>435.12(2)(b-d), FS Background Screening Clearinghouse</p> <p>435.12 Care Provider Background Screening Clearinghouse.-</p> <p>(2)(b) Until such time as the _____ are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency.</p> <p>(c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.</p> <p>(d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic _____ submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; _____; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the employment status of staff members within the employee roster listed in the AHCA background screening clearinghouse within 10 business days of employment for 3 (The Administrator, Staff A and Staff B ) of 3 employees sampled.</p> | CZ814                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |                          |                                                        |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969774</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/25/2022</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANNIES AT CAPEBEND LLC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2011 CAPE BEND AVE<br/>TAMPA, FL 33613</b>                                   |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| CZ814                                                             | <p>Continued From page 1</p> <p>Findings included:</p> <p>During an interview with the Administrator conducted on _____ at 1:23 PM, she stated, she, Staff A and Staff B are currently employed at the facility and provides direct care to the residents. The Administrator confirmed she, Staff A and Staff B has worked at the facility since _____ of 2022. The Administrator stated she has no access to the AHCA background screening clearinghouse portal at this time.</p> <p>On _____ a record review of personnel files for the Administrator showed the Administrator was hired as the Administrator on _____.</p> <p>On _____ a record review of personnel files for Staff A showed Staff A was hired as a direct care staff on _____.</p> <p>On _____ a record review of personnel files for Staff B showed Staff B was hired as a direct care staff on _____.</p> <p>On _____ a record review of the employee roster listed in the AHCA background screening clearinghouse, did not list the current Administrator, Staff A and Staff B, their names were not listed on its active employee roster.</p> <p>Unclassified</p> | CZ814                                                                          |                                                                                                                          |                          |                                                        |

Agency for Health Care Administration

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**ANNIES AT CAPEBEND LLC**

**2011 CAPE BEND AVE  
TAMPA, FL 33613**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 000                    | Continued From page 2                                                                                                                                                                                                                                 | A 000               |                                                                                                                          |                          |
| A 000                    | Initial Comments<br><br>A change of ownership survey was completed at<br>Annies at Capebend, LLC Assisted Living Facility<br>on . Annies at Capebend, LLC<br>Assisted Living Facility had deficient practice<br>identified at the time of the survey. | A 000               |                                                                                                                          |                          |