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
	AL11966458	A. BUILDING: _____ B. WING _____	C 10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TAMPA ASSISTED LIVING	5010 N 40 STREET NORTH TAMPA, FL 33610

(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 numbers: 2022015313 and 2022015657) and a revisit to [redacted] complaint investigation (complaint numbers: 2022011975 and 2022012381) were conducted at Central Tampa Assisted Living on [redacted]. Deficiencies were identified at the time of survey.	A 000		
A 032 SS=G	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times.	A 032		

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A 032	Continued From page 1 2. The facility must have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to assure staff is aware of the residents needs for supervision to prevent elopement, resulting in potential harm to 4 (Resident #1, Resident #2, Resident #4, and Resident #6) of 6 sampled residents.	A 032		

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A 032	Continued From page 2 Findings Included: During an observation conducted on revealed residents were about the facility. Some residents were in bed. Some residents were gathered in television rooms watching television. Some residents were outside in the gazebo or other smoking areas. During a record review conducted on revealed Resident #1 who was admitted on with a diagnosis of associated with /behavioral disturbance and was determined to be an elopement risk on . During a record review conducted on revealed Resident #2 who was admitted on , with a diagnosis of , and was determined to be an elopement risk on . During a focused record review conducted on revealed Resident #4 and Resident #6 were elopement risks. During a review of facilities surveillance cameras conducted on revealed on Resident #2 exited facility through a gate that was supposed to be locked and secured but was found unlocked and unsecured at 9:20pm . Staff discovered the open gate at 9:54pm . During an attempted record review conducted on revealed no elopement drills have been documented as conducted. During a record review conducted on	A 032		

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A 032	Continued From page 3 of the facility elopement policy (undated) stated that ALL EMPLOYEES will participate in an elopement drill at a minimum of twice annually. It is the responsibility of the employee to attend announces drills when such notifications is posted at least one week (7days) in advance. Attendance is mandatory and failure to attend will constitute an unexcused absence. During an interview conducted on at 11:48am with Staff D she stated if the electricity goes out the electric doors will not be locked, so someone should sit at the doors to makes sure no residents get out. During an interview conducted on at 1:20pm with the Administrator he stated he did not have any records of conducting elopement drills. During an interview conducted on at 5:53pm with the Administrator he stated if power goes out and the electric doors are not locking, staff are to sit by exit doors to assure no one exits. (Photo evidence) Class II	A 032		
A 054 SS=D	59A-36.008(5) FAC Medication - Records (5) MEDICATION RECORDS. (a) For residents who use a pill organizer managed in subsection (2), the facility must keep either the original labeled medication container; or a medication listing with the prescription number, the name and address of the issuing pharmacy, the health care provider's name, the resident's name, the date dispensed, the name	A 054		

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A 054	Continued From page 4 and strength of the drug, and the directions for use. (b) The facility must maintain a daily medication observation record for each resident who receives assistance with self-administration of medications or medication administration. A medication observation record must be immediately updated each time the medication is offered or administered and include: 1. The name of the resident and any known [illegible] the resident may have; 2. The name of the resident's health care provider and the health care provider's telephone number; 3. The name, strength, and directions for use of each medication; and, 4. A chart for recording each time the medication is taken, any missed dosages, refusals to take medication as prescribed, or medication errors. (c) For medications that serve as chemical [illegible], the facility must, pursuant to Section 429.41, F.S., maintain a record of the prescribing physician's annual evaluation of the use of the medication. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to update Medication Observation Records (MORs) immediately when medications were offered to four Residents (#1, #3, #5, and #25) of four sampled residents that required assistance with self-administration of medications. Findings Included: During an interview with Staff N, an unlicensed Medication Technician, conducted on [illegible], Staff N stated that the computer kept glitching and sometimes staff were not able to document when they were giving medications to residents	A 054		

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A 054	Continued From page 5 due to the internet kept going down. A MORs review for Residents #1, #3, #5, and #25, conducted on , revealed that Residents #1, #3, #5, and #25's MORs had medications that were not documented as given to the residents which included but not limited to the following findings: , MORs Resident #1's prescribed , 10mg was not documented as given on , , and at 09:00am. 5mg was not documented as given on at 09:00pm. 10mg was not documented on , , and at 09:00am. 25mg was not documented on , , and at 09:00am Resident #3's prescribed , 5mg was not documented as given on through at 09:00am. , 25mcg was not documented as given on at 07:00am. Rosuvastatin 10mg was not documented as given on , , and at 09:00pm. Resident #5's prescribed , 15mg was not documented as given on , , and at 09:00pm. , 0.05mg Metered Dose Spray was not documented as given on , , and at 09:00pm. Resident #25's prescribed Acidophilus was not documented as given on through 09/302022 at 09:00am. , 25mg was not documented as given on and	A 054		

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A 054	Continued From page 6 at 05:00pm and through at 09:00am and 05:00pm. MORs Resident 1's prescribed 10mg was not documented as given on , , and at 09:00am. 5mg was not documented as given on at 09:00pm. 10mg was not documented as given on at 05:00pm and , and at 09:00am. 25mg was not documented as given on , , , and at 09:00am. Resident #5's prescribed , 81mg was not documented as given on at 09:00am. , 0.5mg was not documented as given on at 09:00pm. , 0.5mg was not documented as given on and at 09:00am. , 250mg was not documented as given on at 05:00pm, at 09:00am, at 05:00pm, and at 09:00am and 05:00pm. Resident #25's prescribed , 0.5mg was not documented as given on at 09:00am and at 05:00pm. , 0.5mg was not documented as given on at 09:00pm. During an interview with the Administrator, conducted on at 05:30pm, the Administrator agreed that Residents #1, #3, #5, and #25's had medications that were not documented as given on the , and MORs and stated that the facility was working on obtaining Wi-Fi boosters.	A 054		

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A 054	Continued From page 7 Class III	A 054		
A 077 SS=D	429.176 FS; 429.52( ),59A-36.01(1) FAC Staffing Standards - Administrators 429.176 Notice of change of administrator.-If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements. 429.52 (4) A facility administrator must complete the required core training, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule. (5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years. 59A-36.010 (1) ADMINISTRATORS. Every facility must be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff	A 077		

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A 077	Continued From page 8 and the provision of appropriate care to all residents as required by chapters 408, part II, 429, part I, F.S., and rule chapter 59A-35, F.A.C., and this rule chapter. (a) An administrator must: 1. Be at least ; 2. If employed on or after , have, at a minimum, a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening requirements pursuant to sections 408.809 and 429.174, F.S.; 4. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C., no later than 90 days after becoming employed as a facility administrator. Administrators who attended core training prior to , are not required to take the competency test unless specified elsewhere in this rule; and, 5. Satisfy the continuing education requirements pursuant to rule 59A-36.011, F.A.C. Administrators who are not in compliance with these requirements must retake the core training and core competency test requirements in effect on the date the non-compliance is discovered by the agency or the department. (b) In the event of extenuating circumstances, such as the of a facility administrator, the agency may permit an individual who otherwise has not satisfied the training requirements of subparagraph (1)(a)4. of this rule, to temporarily serve as the facility administrator for a period not to exceed 90 days. During the 90 day period, the individual temporarily serving as facility administrator must: 1. Complete the core training and core competency test requirements pursuant to rule 59A-36.011, F.A.C.; and,	A 077		

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A 077	Continued From page 9 2. Complete all additional training requirements if the facility maintains licensure as an extended congregate care or limited mental health facility. (c) Administrators may supervise a maximum of either three assisted living facilities or a group of facilities on a single campus providing housing and health care Administrators who supervise more than one facility must appoint in writing a separate manager for each facility. However, an administrator supervising a maximum of three assisted living facilities, each licensed for 16 or fewer beds and all within a 15 mile of each other, is only required to appoint two managers to assist in the operation and maintenance of those facilities. (d) An individual serving as a manager must satisfy the same qualifications, background screening, core training and competency test requirements, and continuing education requirements as an administrator pursuant to paragraph (1)(a) of this rule. Managers who attended the core training program prior to , , , , are not required to take the competency test unless specified elsewhere in this rule. In addition, a manager may not serve as a manager of more than a single facility, except as provided in paragraph (1)(c) of this rule, and may not , serve as an administrator of any other facility. (e) Pursuant to section 429.176, F.S., facility owners must notify the Agency Central Office within 10 days of a change in facility administrator on the Notification of Change of Administrator form, AHCA Form 3180-1006, , which is incorporated by reference and available online at: http://www.flrules.org/Gateway/reference.asp?No=Ref-09393.	A 077		

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A 077	Continued From page 10 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to have an qualified Assisted Living Facility CORE trained Administrator. Findings Included: Observations, conducted on from 09:15am through 08:15pm, the Administrator was actively working in the facility and provided assistance during the survey process. A record review for the Administrator, conducted on , revealed that the Administrator had assisted living core training on . The Administrator had 13-hours of core training bi-annual continuing education on . There was no evidence of 12-hours of continuing education obtained by , , , or . There was no evidence in the record that the Aministrator retook the Assisted Living Facility CORE training after noncompliance with adhering to the continuing education requirements. During an interview with the Administrator, conducted on at 05:30pm, the Administrator was unable to provide evidence of 12-hours of continuing education obtained by , , , or . Class III	A 077		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA	A 165		

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A 165	Continued From page 11 429.23 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, through the agency's online portal, or if the portal is offline, by electronic mail, a	A 165		

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A 165	Continued From page 12 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, through the agency's online portal, or if the portal is offline, by electronic 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) , neglect, or , 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	A 165		

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A 165	Continued From page 13 this fact to such regulatory board. (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 agency may adopt rules necessary to administer this section. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to provide an accurate adverse incident report (AIRS) within 1 business day of an incident for 1 (Resident #2) of 2 sampled residents. Findings Included: During an attempted record review of the AIRs log conducted on revealed the 1-day adverse incident report for Resident #2 who eloped from the facility on was not submitted. During a review of facilities surveillance cameras conducted on revealed Resident #2 exited facility through a gate that was supposed to be locked and secured but was found unlocked and unsecured at 9:20pm. Staff discovered the open gate at 9:54pm. During an interview conducted on at 12:49pm with the Administrator he confirmed an adverse incident report was not submitted for Resident #2. Class III	A 165		