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 |
|---|---|---|---|
| | AL11967351 | A. BUILDING: _____ B. WING _____ | R 02/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **TORIA'S ASSISTED LIVING FACILITY I** | **2073 BALFOUR CIRCLE TAMPA, FL 33619** |

| (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<br><br>A 2nd revisit to and abbreviated biennial survey was completed at Toria's Assisted Living Facility I on . Toria's Assisted Living Facility I had deficient practice identified at the time of the survey. | {A 000} | | |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 |
|---|---|---|---|
| | AL11967351 | A. BUILDING: _____ B. WING _____ | R 02/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORIA'S ASSISTED LIVING FACILITY I | 2073 BALFOUR CIRCLE TAMPA, FL 33619 |

| (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 |
|---|---|---|---|---|
| {CZ813} | 59A-35.090(3)(c), FAC Results of Screening & Notification In File<br><br>59A-35.090 Background Screening.<br>(3) Results of Screening and Notification.<br>(c) The eligibility results of employee screening and the signed Attestation referenced in subsection 59A-35.090(2), F.A.C., must be in the employee's personnel file, maintained by the provider.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to maintain the employment status of staff members within the employee personal file at all times for 1 (The Administrator) of 3 employees sampled.<br><br>Findings included:<br><br>On , a record review of the Administrator's personnel file was completed. The personnel file showed eligible status for her level II background screening on . . . . . . . Records did not include an eligible status within the last 5 years, no new screening was available for review.<br><br>During an interview on . . . . . at 12:17 PM, the Administrator confirmed that she is currently employed at the facility as the Administrator. The Administrator confirmed that she could not provide a physical copy of her AHCA Level II background screening document to show an eligible status after the . . . . . eligibility date.<br><br>Unclassified | {CZ813} | | |
| {CZ814} | 435.12(2)(b-d), FS Background Screening Clearinghouse | {CZ814} | | |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 |
|---|---|---|---|
| | AL11967351 | A. BUILDING: _____ B. WING _____ | R 02/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORIA'S ASSISTED LIVING FACILITY I | 2073 BALFOUR CIRCLE TAMPA, FL 33619 |

| (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 |
|---|---|---|---|---|
| {CZ814} | Continued From page 1<br><br>435.12 Care Provider Background Screening Clearinghouse.-<br>(2)(b) Until such time as the [illegible] 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.<br>(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.<br>(d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic [illegible] 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; [illegible]; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to register 1 (Administrator) out of 3 sampled staff with the Agency for Healthcare Administration (AHCA) Background Screening Clearinghouse within 10 days upon initial employment.<br><br>Findings Included: | {CZ814} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967351 | A. BUILDING: _____ B. WING _____ | R 02/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORIA'S ASSISTED LIVING FACILITY I | 2073 BALFOUR CIRCLE TAMPA, FL 33619 |

| (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 |
|---|---|---|---|---|
| {CZ814} | Continued From page 2<br><br>On [redacted] a record review of the employee roster listed in the AHCA background screening clearinghouse revealed, that the Administrator was not on its active employee roster.<br><br>During a phone interview with the Administrator on [redacted] at 12:15 PM, she stated that she is the current facility administrator for many months. The administrator confirmed that she believes she is currently listed on the employee roster. | {CZ814} | | |
| {CZ830} SS=D | 408.821 FS Emergency Management Planning<br><br>408.821 Emergency management planning; emergency operations; inactive license.-<br>(1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:<br>(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.<br>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.<br>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.<br>(d) Notify the agency within 30 days after | {CZ830} | | |

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 |
|---|---|---|---|
| | AL11967351 | A. BUILDING: _____ B. WING _____ | R 02/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORIA'S ASSISTED LIVING FACILITY I | 2073 BALFOUR CIRCLE TAMPA, FL 33619 |

| (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 |
|---|---|---|---|---|
| {CZ830} | Continued From page 3 | {CZ830} | | |

approval of its plan by the local emergency management agency, county health department, or Department of Health.
(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.
(3)(a) An inactive license may be issued to a licensee subject to this section when the provider is located in a geographic area in which a state of emergency was declared by the Governor if the provider:
1. Suffered damage to its operation during the state of emergency.
2. Is currently licensed.
3. Does not have a provisional license.
4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.
(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967351 | A. BUILDING: _____ B. WING _____ | R 02/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORIA'S ASSISTED LIVING FACILITY I | 2073 BALFOUR CIRCLE TAMPA, FL 33619 |

| (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 |
|---|---|---|---|---|
| {CZ830} | Continued From page 4 | {CZ830} | | |

approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.

(4) . . . Licensees providing residential or inpatient services must utilize an online database approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.

This Statute or Rule is not met as evidenced by:
Based on interview the facility failed to provide evidence of an approved Comprehensive Emergency Management Plan (CEMP).

Findings included:

A revisit to biennial survey was attempted on . . . . . .

An attempted record review was conducted on of the facility CEMP approval letter. However, the CEMP approval status was not available for review.

The status of the facility's CEMP was discussed with the Administrator (via telephone) on at 11:15 AM. During this discussion

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 |
|---|---|---|---|
| | AL11967351 | A. BUILDING: _____ B. WING _____ | R 02/06/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TORIA'S ASSISTED LIVING FACILITY I | 2073 BALFOUR CIRCLE TAMPA, FL 33619 |

| (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 |
|---|---|---|---|---|
| {CZ830} | Continued From page 5<br><br>the administrator confirmed that the CEMP had not been approved and stated,". No, we don't have the CEMP approval yet, but we are working on it." The administrator confirmed she hasn't had an approval since the year of 2021.<br><br>Class III | {CZ830} | | |