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
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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: 2023008497, 2023009810, and 2023009832) and a generator monitoring were conducted at Arbor Terrace at Citrus Park on . Deficiencies were identified at the time of survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall 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 must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. 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	A 025		

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
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 025	Continued From page 1 resident diets in accordance with Rule 59A-36.012, 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 observation, record review, and interview, the facility failed to provide adequate personal supervision related to the safety and well-being for two of two sampled residents (Resident #5 and #10) that used the facility transport bus. Furthermore, the facility failed maintain the facility transportation bus in good working order and failed to ensure that residents were properly secured in the transport bus before and during transport resulting in injury to one of the two sampled residents (Resident # #5). Findings Included:	A 025		

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
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 025	Continued From page 2 A record review for Resident #5, conducted on , revealed that Resident #5 was admitted to the facility on . According to Resident #5's health assessment dated , the resident had a diagnosis of 's , , , , , and . Resident #5 required assistance with ambulation and transferring. Resident #5's use of a wheelchair was not noted on the health assessment form. Resident #5's record had noted that on , the resident was transported on the community bus to a doctor's , , and when the driver attempted to make a left turn, Resident #5's wheelchair tipped over towards the left side of the bus. It was documented that there were four straps hooked to the wheelchair and the seatbelt attached. Resident #5 was sent to the hospital's emergency department and sustained an to the left side of his forehead. During an interview with the Driver, conducted on at 10:48am, the Driver stated that he secured wheelchairs in the bus by placing two safety hooks (referring to retractors) on the front of the chair and one on the of the chair and then placed the harness seatbelt around the resident. The Driver stated that the hooks were loose and rotated (swiveled) and that there was usually a shift in the wheelchairs after securing the wheelchairs. The Driver stated that there was no manual that identified the proper placement of the hooks, latches, harnesses, and retractors. The Driver was unable to state how long that the retractors were missing, when the hooks became loose, and when the retractors started to swivel. The Driver stated that "it's been like this". The Driver stated that on while transporting Resident #5 in the facility's bus, the	A 025		

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
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 025	Continued From page 3 Driver made a right turn and hit a dip in the road and then he heard yelling. The Driver stated that he looked in the review mirror and saw that Resident #5's wheelchair had tipped over. The Driver was not able to explain how Resident #5's wheelchair had tipped over during transport and stated that all the latches and harnesses were in place. During an interview with the Activity's Director, conducted on . . . . . at 11:55am, the Activity Director stated that there should be four retractors for securing the wheelchair in the bus. Two of the retractors were in the front of the wheelchair and two retractors in the . . . . of the wheelchair. The Activity Director provided the facility's training video entitled Q' Straight QRT Wheelchair . . . . . for securing residents in wheelchairs in the facility's transport bus found at (https://www.youtube.com/watch?v=3AnIXJZIAM M). A review of the training video provided by the Activity's Director, conducted on . . . . . , the training video revealed that each wheelchair had its own transport space in the rear of the bus. Each wheelchair transport space was supposed to have two retractors for the front of the wheelchair's frame and two retractors for the . . . . of the wheelchair's frame. The . . . . two wheels of the wheelchair were supposed to be positioned on the outside of the retractor tracks for its own space. The left wheelchair transport space's . . . . retractor tracks had a retractor in each track. The right wheelchair transport space's . . . . retractor tracks had a retractor in each track. The retractor's securement belt was around a spool that was automatic and self-locking. The automatic feature prevented any slack in the belt and locked the belt with secured tension. To secure the wheelchair, the wheelchair was	A 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 025	Continued From page 4 positioned forward facing and centered squarely within the rectangle formed by the four anchor points and lock the wheelchair locks. After inspection, the four Q Straight QRT Max retractors were to attach in the anchor system and in the tracks. The front securements should be attached outside or wider than the width of the chair and angle slightly outward up to a 25-degree angle to reach the chair frame. The rear retractors were positioned inside or narrower than the wheels. For maximum safety, the rear straps should make a 30-to-45-degree angle with the floor. Once all the securements are attached, the wheelchair wheels were unlocked for movement test. If the chair moved, the securements were not fastened correctly and required investigation until the chair was not movable. The automatic self-tensioning and self-locking QRT Max Retractors prevented any remaining slack throughout the trip. At no point in the video, were the retractors observed to swivel 360 degrees or any other degree. The retractors appeared fixed. During an observation with the Activity Director while the Driver secured Resident #10's wheelchair into the transport bus for an outing, conducted on at 01:15pm, revealed that the facility's bus had missing and faulty equipment (QRT Max Retractors). There were six of the eight retractors present. One of the retractors swiveled 360 degrees. The Driver positioned Resident #10's wheelchair with the wheels in the middle of the rear of the bus. There was a left and right wheelchair space. The Driver positioned Resident #10's wheelchair in the middle of the two wheelchair spaces so that the wheels had one retractor tract on the outside of each wheelchair wheel and one retractor tract underneath the wheelchair wheels. The	A 025		

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
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 025	Continued From page 5 Driver used the left wheelchair space's right retractor and the right wheelchair space's right retractor to secure Resident #10's wheelchair. The right retractor for the right wheelchair space spun/moved 360 degrees. Resident #10's wheelchair was still moveable and loose. The Driver stated that there were two retractors missing and that he used two in the front of the wheelchair and one in the of the wheelchair when transporting two wheelchairs. The Driver stated that when transporting one wheelchair, he placed the wheelchair in the middle of the of the bus in which there was one retractor track on the outside of each wheelchair wheels and one underneath the wheelchair. The Driver stated that he used the right retractor from the left wheelchair space and the right retractor from the right wheelchair space to secure one wheelchair in the bus. During an interview with the Activity Director, conducted on at 01:15pm, the Activity Director agreed that Resident #10 was not correctly positioned or secured in the bus. The Activity Director was not sure whether the retractors were supposed to be able to swivel 360 degrees. The video was re-reviewed with the Activity Director. The Activity Director agreed that the retractor's appeared fixed and unable to swivel 360 degrees. During an interview with Administrator, conducted on at 03:45pm, the Administrator agreed that the facility's bus was missing two retractors for safely securing wheelchairs during transport on the facility's bus. The Administrator was unable to provide documentation that the facility's bus transport equipment had been checked or maintained in good working order.	A 025		

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
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 025	Continued From page 6 Class II	A 025		
A 165 SS=D	429.23(&) FS Risk Mgmt & QA 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.	A 165		

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
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 165	Continued From page 7 (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 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	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 165	Continued From page 8 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. (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 observation, record review, and interview, the facility failed to submit a one-day adverse incident report to the Agency when one Resident (#5) of one sampled resident had a with a injury while being transported in the facility's bus. Findings Included: A record review for Resident #5, conducted on , revealed that Resident #5 sustained an to the left side of his forehead during transport to a medical , , on when his wheelchair tipped over as the Driver made turn. Resident #5 was transported to a local hospital for treatment. During an observation of the facility's bus transport equipment, conducted on at 01:15pm, revealed that there were two of eight retractors missing and one retractor that swiveled 360 degrees.	A 165		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 165	Continued From page 9 During an interview with the Activity's Director, conducted on at 11:55am, the Activity Director agreed that there were two retractors missing. At 01:15pm, the Activity Director agreed that the retractors were supposed to be fixed and unable to swivel 360 degrees. During an interview with the Driver, conducted on . . . . . at 10:48am, the Driver stated that the hooks (retractors) were loose and rotated (swiveled) and that there was usually a shift in the wheelchairs after securing the wheelchairs. The Driver was unable to state how long that the retractors were missing, when the hooks became loose, and when the retractors started to swivel. The Driver stated that "it's been like this". The Driver stated that on . . . . . while transporting Resident #5 in the facility's bus, the Driver made a right turn and hit a dip in the road and then he heard yelling. The Driver stated that he looked in the rearview mirror and saw that Resident #5's wheelchair had tipped over. The Driver was not able to explain how Resident #5's wheelchair had tipped over during transport and stated that all the latches and harnesses were in place. Later during an interview with the Driver at 01:15pm, the Driver stated that there were two retractors missing. During an attempt to review an adverse incident report for Resident #5, conducted on . . . . . , revealed that the facility did not submit a one-day adverse incident report for Resident #5 related to injury on . During an interview with Administrator, conducted on . . . . . at 03:35pm, the Administrator agreed that the facility's bus was missing two retractors for safely securing wheelchairs to the bus during transport. The Administrator was	A 165		

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
	AL11968783	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE AT CITRUS PARK	13810 SHELDON RD TAMPA, FL 33626

(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 165	Continued From page 10 unable to provide documentation that the facility's bus transport equipment had been checked or maintained in good working order. The Administrator was unable to provide a one- and fifteen-day adverse incident report for Resident #5's preventable hospitalization. Class III	A 165		