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
	AL11965634	A. BUILDING: _____ B. WING _____	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SODALIS TAMPA	2626 WEST BEARSS AVENUE TAMPA, FL 33618

(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 (complaint numbers 2024016812, 2025000415, 2025000946 & 2025001505) survey with a generator monitoring survey was conducted at Sodalis Tampa on . The facility had deficiecies at the time of survey.	A 000		
A 025 SS=D	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		

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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, interview and record review, the Facility failed to provide care, services, and supervision appropriate to the needs of the residents accepted for admission to the facility for three (Resident #3, Resident #7 and Resident #10) of three sampled residents. Findings Included: In an observation or Resident #3's room conducted on At 10:13am there was a strong stench of in the room and bathroom making it difficult to breathe. There was	A 025		

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A 025	Continued From page 2 a puddle of liquid on the floor at the of his recliner chair. There were soda and water bottles and a white to go food container on the floor underneath the side table. The resident was sitting in his recliner on an , and appeared unkempt with small brown spots/stains on his shirt and messy hair. In an observation of Resident #7 conducted on at 11:01am there was a very strong stench of in the room. There were paper towels strewn around the floor, crumbs and black particles/dirt on the floor in front of the dresser. There was a plastic razor, broken plastic fork, a nail file and a square container of thumb tacks on the floor under the bedside table next to the recliner. Additionally, there was an , at the of the chair on the floor and a bathroom rug stuck under the wheel of the electric wheelchair that had paper stuck to the wheels. In an observation of Resident #10 conducted on at 10:35am there was a very strong stench of inside the room. Additionally, there was a large laundry bag and trash bag full of dirty clothes. At 10:39am staff arrived to take her clothes to be washed and told them they would return them when cleaned. In a record review for Resident #7 conducted on the Agency for Healthcare Administration (AHCA) 1823 Resident Assessment dated revealed a diagnosis of , , a risk and said resident required assistance with bathing, , self care and transfers. There was a note by the physician dated that listed a diagnosis of , .	A 025		

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A 025	Continued From page 3 In an interview with Resident #5 conducted on at 10:32am they said the staff sometimes would not answer call lights for hours and that if there was ever an emergency like a few incidents in the past where they were left on the floor or left on the toilet for over 20 minutes. In an observation conducted on at 10:38am of Resident #13 the call light was pressed at 10:38am. Two direct care staff arrived to answer the call light at 10:52am. In an interview with Resident #12 conducted on at 11:08am they said that housekeeping came once a week but that the staff responsible for taking out the garbage on the second shift would not do it and the garbage would overflow. Additionally, they said the facility staff did not help them with what they needed as the laundry and garbage piled up and they would press the call pendant, and no one would come. In an interview with the Director Housekeeping and Maintenance conducted on at 11:45am he said his staff were expected to do a deep cleaning weekly for Resident #3, Resident #7 and Resident #10. He said that Resident #7 was messy and would do things she shouldn't, and he did not feel it was his staff's responsibility to clean out of the garbage can. Additionally, he said Resident #3 was very depressed, was kicked off of an end-of-life program, and was on his third recliner in six months due to . While he said he had a good rapport with him to encourage showers previously, he felt the resident had taken a bad turn recently into old behaviors. Furthermore, he said it was the resident aide responsibility to check the garbage when going	A 025		

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A 025	Continued From page 4 into the resident rooms on their shift and that they also handled the laundry. In an attempted record review of the facility housekeeping log conducted on no log was provided. In an interview with the Executive Director conducted on at 1:35pm she said that Resident # 3 was sheltered in the room and his daughter was worried about it and she would be meeting with the family and that the staff needed to make sure they were taking care of him. Additionally, she said that staff needed to be consistent with issues for Resident #10 and follow through with help for her. She also said Resident #7 needed "tough love" and was a known hoarder before this recent room change. In an interview with the Health and Wellness Director conducted on at 1:55pm she said the best practice for call light response was 7 minutes and if unable to make it the staff were to radio over the radio to tell the other aides. She said the delay in response time on survey was a teachable moment. Class III (Photographic Evidence Obtained)	A 025		
A 052 SS=D	429.256( ): 59A-36.008(3) Medication - Assistance with Self-Admin 429.256 (3) Assistance with self-administration of medication includes: (a) Taking the medication, in	A 052		

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A 052	Continued From page 5 its previously dispensed, properly labeled container, from where it is stored, and bringing it to the resident. For purposes of this paragraph, an syringe that is prefilled with the proper dosage by a pharmacist and an , that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers. (b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change. (c) Placing an oral dosage in the resident's or placing the dosage in another container and helping the resident by lifting the container to his or her . (d) Applying , medications. (e) Returning the medication container to proper storage. (f) Keeping a record of when a resident receives assistance with self-administration under this section. (g) Assisting with the use of a , including removing the cap of a , opening the unit dose of solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the . (4) Assistance with self-administration of medication does not include: (a) Mixing, , converting, or	A 052		

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A 052	Continued From page 6 ِ medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed. (b) The preparation of syringes for injection or the administration of medications by any injectable route. (c) Administration of medications by way of a tube inserted in a ِ of the body. (d) Administration of ِ preparations. (e) The use of irrigations or debriding agents used in the treatment of a skin condition. (f) Assisting with ِ ِ or ِ preparations. (g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication. (h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person. (5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003. 59A-36.008 (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) Any unlicensed person providing assistance with self-administration of medication must be ِ ِ or older, trained to assist with self	A 052		

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A 052	Continued From page 7 administered medication pursuant to the training requirements of Rule 59A-36.011, F.A.C., and must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S. and this rule. (b) In addition to the specifications of Section 429.256(3), F.S., assistance with self-administration of medication includes, orally advising the resident of the name and dosage of the medication and verbally prompting a resident to take medications as prescribed. (c) In order to facilitate assistance with self-administration, trained staff may prepare and make available such items as water, juice, cups, and spoons. Trained staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, must not be returned to the container. (d) Trained staff must observe the resident take the medication. Any concerns about the resident's reaction to the medication or suspected noncompliance must be reported to the resident's health care provider and documented in the resident's record. (e) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed: 1. The health care provider may prescribe a medication schedule that coincides with the resident's presence in the facility, 2. The medication container may be given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, 3. The medication may be transferred to a pill organizer pursuant to the requirements of	A 052		

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A 052	Continued From page 8 subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident's medication record, or 4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging. (f) Assistance with self-administration of medication does not include the activities detailed in Section 429.256(4), F.S. (g) As used in Section 429.256(4)(h), F.S., the terms "judgment" and "discretion" mean interpreting vital signs and evaluating or assessing a resident's condition. (h) All trained staff must adhere to the facility's control policy and procedures when assisting with the self-administration of medication. This Statute or Rule is not met as evidenced by: Based on observation and interview, the Facility failed to advise the resident of the medication name and dosage for one (Resident #1) of one sampled resident that required assistance with self-administration of medication . Findings Included: During an observation of the medication pass with Staff A (unlicensed Medication Technician) for Resident #1 conducted on at 9:59am she popped 13 pill packs (14 pills) into a clear medicine cup in the hallway while the resident stood in the doorway. She did not say the name of the medication she was popping into the cup or the dosage of the medication. The resident entered her room as Staff A was still pulling medications from the medication cart and told Staff A to just come in when she was ready. Staff	A 052		

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A 052	Continued From page 9 A then entered the room and handed the cup of pills to the resident, telling her they were her "10:00am medications." The resident poured all 14 pills onto her placemat on the table. When she got to the last pill she asked Staff A what the pill was. They both looked at the pill and tried to guess if it was C or not. Staff A offered to go to the med cart to look at the pills to see which one it was, but the resident declined. In an interview with Resident #6 conducted on at 11:16am she said the Medication Technicians did not tell her what medications she was getting. In an interview with Staff A conducted on at 10:05am when asked if she would usually pop out the pills away from the resident or tell them what they were getting, she said she did not remember if she needed to tell them what they were getting, and would just look in the system and give them because she could not pronounce all of the names. In an interview with the Executive Director conducted on at 12:50pm she said the Medication Technicians should tell the residents the medication name and dosage and pull pills in front of the resident. Class III	A 052		
A 160 SS=D	59A-36.015(1) FAC Records - Facility 59A-36.015 Records. The facility must maintain required records in a manner that makes such records readily available	A 160		

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A 160	Continued From page 10 at the licensee's physical address for review by a legally authorized entity. If records are maintained in an electronic format, facility staff must be readily available to access the data and produce the requested information. For purposes of this section, "readily available" means the ability to immediately produce documents, records, or other such data, either in electronic or paper format, upon request. (1) FACILITY RECORDS. Facility records must include: (a) The facility's license displayed in a conspicuous and public place within the facility. (b) An up-to-date admission and discharge log listing the names of all residents and each resident's: 1. Date of admission, the facility or place from which the resident was admitted, and if applicable, a notation indicating that the resident was admitted with a , ; and, 2. Date of discharge, reason for discharge, and identification of the facility or home address to which the resident was discharged. Readmission of a resident to the facility after discharge requires a new entry in the log. Discharge of a resident is not required if the facility is holding a bed for a resident who is out of the facility but intending to return pursuant to Rule 59A-36.018, F.A.C. If the resident dies while in the care of the facility, the log must indicate the date of . (c) A log listing the names of all temporary emergency placement and respite care residents if not included on the log described in paragraph (b). (d) The facility's emergency management plan, with documentation of review and approval by the county emergency management agency, as described in Rule 59A-36.019, F.A.C., that must be readily available by facility staff.	A 160		

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A 160	Continued From page 11 (e) The facility's liability insurance policy required in Rule 59A-36.013, F.A.C. (f) For facilities that have a surety bond, a copy of the surety bond currently in effect as required by Rule 59A-36.013, F.A.C. (g) The admission package presented to new or prospective residents (less the resident's contract) described in Rule 59A-36.006, F.A.C. (h) If the facility advertises that it provides special care for persons with 's or related , a copy of all such facility advertisements as required by Section 429.177, F.S. (i) A grievance procedure for receiving and responding to resident complaints and recommendations as described in Rule 59A-36.007, F.A.C. (j) All food service records required in Rule 59A-36.012, F.A.C., including menus planned and served and county health department inspection reports. Facilities that contract for food services, must include a copy of the contract for food services and the food service contractor's license or certificate to operate. (k) All fire safety inspection reports issued by the local authority or the State Fire Marshal pursuant to Section 429.435, F.S., and rule Chapter 69A-40, F.A.C., issued within the last 2 years. (l) All sanitation inspection reports issued by the county health department pursuant to Section 381.031, F.S., and Chapter 64E-12, F.A.C., issued within the last 2 years. (m) Pursuant to Section 429.35, F.S., all completed survey, inspection and complaint investigation reports, and notices of sanctions and moratoriums issued by the agency within the last 5 years. (n) The facility's resident elopement response policies and procedures.	A 160		

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A 160	Continued From page 12 (o) The facility's documented resident elopement response drills. (p) The facility's policies and procedures pursuant to subsection 59A-36.007(10), F.A.C.; (q) The facility's prevention policies and procedures; (r) The facility's medication practices; (s) The facility's policy on physical ; (t) The facility's policy on assistive devices; (u) The facility's policy on third-party providers; (v) The facility's policy on visitation pursuant to Section 408.823(2)(a), F.S.; (w) For facilities licensed as limited mental health, extended congregate care, or limited nursing services, records required as stated in Rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure an up to date admission discharge log listing the date of discharge and reason for discharge for two (Resident #16 and Resident #17) of two sampled residents. Findings included: A record review of a current list of residents provided by the facility was conducted on revealed Resident #16 and Resident #17 was not list as a current resident. A record review of the admission discharge log was conducted on revealed Resident #16 and Resident #17 did not have a date of discharge or reason for discharge. An interview was conducted with the Administrator on at 1:30p.m. who agreed that Resident #16 and Resident #17 are	A 160		

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A 160	Continued From page 13 no longer residents and there was no discharge date or reason for discharge written in the admission discharge log. Class III (photographic evidence obtained)	A 160		