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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 Assisted Living Facility A complaint survey, CCR# 2012006511, was conducted in conjunction with a revisit survey, see (Aspen Event KQRI12), and two unlicensed complaint, CCR# 2012006519, see (Aspen Event N4XQ11), and CCR# 2012006516, see (Aspen Event YDLC11), on ..... Feel at Home, Inc. assisted living facility had deficiencies found at the time of the visit.	A 000		
A 004	58A-5.016 FAC Licensure - Requirements License Requirements. (1) SERVICE PROHIBITION. An ALF may not hold itself out to the public as providing any service other than a service for which it is licensed to provide. (2) LICENSE TRANSFER PROHIBITION. Licenses are not transferable. Whenever a facility is sold or ownership is transferred, including leasing, the transferor and transferee must comply with the provisions of Section 429.41, F.S., and the transferee must submit a change of ownership license application pursuant to Rule 58A-5.014, F.A.C. (3) CHANGE IN USE OF SPACE REQUIRING CENTRAL OFFICE APPROVAL. A change in the use of space that increases or decreases a facility ' s capacity shall not be made without prior approval from the Agency Central Office. Approval shall be based on the compliance with the physical plant standards provided in Rule 58A-5.023, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation requirements as referenced in Rule 58A-5.0161, F.A.C. (4) CHANGE IN USE OF SPACE REQUIRING	A 004		

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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 004	Continued From page 1	A 004		

FIELD OFFICE APPROVAL. A change in the use of space that involves converting an area to resident use, which has not previously been inspected for such use, shall not be made without prior approval from the Agency Field Office. Approval shall be based on the compliance with the physical plant standards provided in Rule 58A-5.023, F.A.C., as well as documentation of compliance with applicable fire safety and sanitation standards as referenced in Rule 58A-5.0161, F.A.C.

(5) CONTIGUOUS PROPERTY. If a facility consists of more than one building, all buildings included under a single license must be on contiguous property. " Contiguous property " means property under the same ownership separated by no more than a two-lane street that traverses the property. A licensed location may be expanded to include additional contiguous property with the approval of the agency to ensure continued compliance with the requirements and standards of Part I, Chapter 429, F.S., and this rule chapter.

(6) PROOF OF INSPECTIONS. A copy of the annual fire safety and sanitation inspections described in Rule 58A-5.0161, F.A.C., shall be submitted annually to the Agency Central Office. The annual inspections shall be submitted no later than 30 calendar days after the inspections. Failure to comply with this requirement may result in administrative action pursuant to Section 429.14, F.S., and Rule 58A-5.033, F.A.C.

(7) MEDICAID WAIVER RESIDENTS. Upon request, the facility administrator or designee must identify Medicaid waiver residents to the agency and the department for monitoring purposes authorized by state and federal laws.

(8) THIRD PARTY SERVICES.

(a) In instances when residents require services from a third party provider, the facility

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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 004	Continued From page 2 administrator or designee must take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals, unless residents or their representatives decline the assistance. The declination of assistance must be reviewed at least annually. These actions must be documented in the resident ' s record. (b) In instances when residents or their representatives arrange for third party services, the facility administrator or designee, when requested by residents or representatives, must take action to assist in facilitating the provision of those services and coordinate with the provider to meet the specific service goals. These actions must be documented in the resident ' s record. (c) The facility ' s facilitation and coordination as described under this subsection does not represent a guarantee that residents will receive third party services. If the facility ' s efforts at facilitation and coordination are unsuccessful, the facility should include this documentation in the resident ' s record, explaining the reason or reasons its efforts were unsuccessful, which will serve to demonstrate its compliance with this subsection. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that it obtained compliance with physical plant standards, compliance with applicable fire safety and sanitation standards for a change in use of space for 2 addresses, 131 W. 131st Avenue, Tampa, FL. 33612 and 118 Prince Street, Tampa FL 33612 as evidenced by 1 (#1) of 9 sampled resident currently residing at the unlicensed contiguous property of 131 W. 131st Avenue and as evidenced by 5 (#5, 6, 7, 8 and 9) of 9	A 004		

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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 004	Continued From page 3	A 004		

sampled residents reporting to have spent the night at the unlicensed contiguous property at 118 Prince Street. Failing to ensure that residents are properly placed in licensed space can place residents at risk to be exposed to unsafe conditions of the physical plant.

Findings include:

A record review of a facility profile for Feel At Home Assisted Living facility at 129 W. 131st Ave. Tampa FL, revealed the license to be for 16 beds. During the entrance to the facility on [redacted] at approximately 9:10 a.m., the main building census was reported to be 14 residents by the provider, Staff member A.

(A)During an interview, conducted on [redacted] at approximately 9:20 a.m., an individual was observed sitting on the front porch of the home at 131 w. 131st Avenue. The individual, Resident #1 stated that he lived at the address by himself. Resident was observed to be clean and he was not able to answer questions readily. During a review of the Hillsborough County Property Appraiser web site, it documented that the owner of the 131 W. 131st Avenue was the owner of the adjacent property, Staff member B. The adjacent property to the east of the 131 address is "Feel At Home" Assisted Living facility at 129 W. 131st Avenue, license # 4653. A tour of the 131 address was conducted on [redacted] at approximately 10:25 a.m. with the Staff member A of Feel at Home ALF. She stated that 1 person lived in the 131 address. The home was observed to have 4 [redacted] and one bath. The [redacted] were observed and found to have one that appeared to be occupied, reportedly by Resident #1. A [redacted] the North West corner, appeared to be unoccupied, the floor had

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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 004	Continued From page 4 a hole in it approximately 1 foot by 1 foot. The home had a common area that was clean and clear. The dining had a home health folder present, it was noted that Resident #1 was in receipt of Physical During the tour of the home at 131 W. 131st Avenue, a utility a washer and a dryer that was located mid house on the east side; the ceiling above the washer and dryer had caved in , 2 areas of damage. One area above the washer and dryer was approximately 8 feet by 6 feet with insulation and debris hanging down. Another ceiling area approximately 4 feet by 4 feet was caved in on the east side of the . Ceiling debris was present on the washer, dryer and floor presenting unsafe conditions. During the tour an observation of a plastic 2 week container of medication was present on the refrigerator. The container had Resident #1 ' s name on it and pills were present in the container. During an interview conducted on at approximately 11:00 a.m. with Staff member A, she confirmed that originally, Resident #1 was competing a stay at the Veterans Administration, that the discharge planner was looking for placement for the resident and that she, the provider had originally planned to admit Resident #1 to the Feel at Home Assisted Living Facility (ALF). The provider was unclear of the dates when this occurred. The provider further stated that Resident #1 came and stayed at Feel at Home ALF, but, he did not like it and the resident requested to stay and rent at the 131 W. 131st Avenue address. The provider confirmed that Resident #1 paid $1,000/mo for rent which includes utilities. During a record review of a Health Assessment, 1823, dated , for Resident #1, it documented that Resident #1 was to receive	A 004		

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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 004	Continued From page 5	A 004		

assistance with medication set up, administration and arrangement and that in the opinion of the physician, the resident ' s needs could be met at an ALF. The 1823 further documented that Resident #1 was to receive assistance with self-care tasks such as preparing meals, shopping and making phone calls. The form further stated that the resident needed daily oversight in regards to observing the individual ' s wellbeing and whereabouts and reminding the individual of important tasks.

During a facility file review of license # 4653, Feel at Home, Inc., the Assisted Living License was issued to include only the building located at 129 W. 131st Avenue. Further review of the address at 131 W. 131st Avenue, the home was determined not to be licensed space.

It could be determined that the provider was allowing Resident #1 to reside in unlicensed space (contiguous property) that had not been approved by the Agency or that it had met compliance with applicable fire and sanitation standards.

(B)During an interview conducted on . . . . . at approximately 10:45a.m. with Resident #5,he stated that residents stay at the main facility (129 W. 131st Avenue), next door (131 W. 131st Avenue) and behind the main building (118 Prince Street). He further stated that Resident #6 and Resident #7 had stayed at the 118 Prince Street.

During an interview conducted on . . . . . at approximately 10:55 a.m. with Resident #8, he confirmed that he had spent the night next door (131 W. 131st Avenue) recently. He further stated that when he first moved in, he stayed at the 118 Prince Street address for a few months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 004	Continued From page 6	A 004		

Currently he confirmed that he resided at the main house, 129 W. 131st Ave. and that he received Optional State Supplement monies, the facility held his money; he is provided meals and assistance with medication.

During an interview conducted on at approximately 11:10 a.m. with Resident # 9, he confirmed that he currently resided at the main house, 129 W. 131st Ave., and that he receives assistance with medications. He further stated that when he moved in back in he stayed at the back building on Prince Street; he stated that it was terrifying and that there were holes in the wall caused by animals. He confirmed that Resident #6 had stayed at the Prince Street address.

During a review of the Hillsborough County Property Appraiser's web site it was noted that the property was owned by Staff member A, the provider at Feel At Home. The home at 118 Prince Street backs up to the Feel At Home Assisted living facility and is accessible thru a gate in the back fence (Contiguous Property). During a facility file review of license # 4653, Feel at Home, Inc., the Assisted Living License was issued to include only the building located at 129 W. 131st Avenue. Further review of the address at 118 Prince Street home was determined not to be licensed space.

It could be determined that the provider was allowing Resident #5, 6, 7, 8, and 9 to reside in unlicensed space (contiguous property) at various points in time and that the Prince Street address had not been approved by the Agency nor that it had met compliance with applicable fire and sanitation standards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 004	Continued From page 7 Class III Pattern	A 004		
A 092	58A-5.020(1) FAC Food Service - General Responsibilities Food Service Standards. (1) GENERAL RESPONSIBILITIES. When food service is provided by the facility, the administrator or a person designated in writing by the administrator shall: (a) Be responsible for total food services and the day to day supervision of food services staff. (b) Perform his/her duties in a safe and sanitary manner. (c) Provide regular meals which meet the nutritional needs of residents, and therapeutic diets as ordered by the resident ' s health care provider for resident ' s who require special diets. (d) Maintain the in-service and continuing education requirements specified in Rule 58A-5.0191, F.A.C. This Statute or Rule is not met as evidenced by: Based on observation and interview, the provider failed to ensure that it performed her food service duties in a safe and sanitary manner with regards to housing and potentially serving meat from an unknown source to the resident population (14 residents) as evidenced by multiple bags of meat contained in plastic grocery bags in the freezer and refrigerator of the facility. Obtaining meat from an unknown source can place residents at risk for food borne illness. Findings include:	A 092		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 092	Continued From page 8	A 092		

During the entrance to the facility on at approximately 9:10 a.m., the provider stated that the census of the facility was 14 residents.

During the tour of the facility on at approximately 10:00 a.m. a plastic grocery bag was observed in a pan over the sink. When the bag was touched, the temperature of the bag was The bag was opened by the provider and multiple steak like meat parts were present in the bag. Observed on the counter in another pan was a bag of onions that appeared to have been sliced and cooked. The bag of onions was touched and found to be at Initially at the time of observation, the provider was interviewed as to the purpose of the meat and onions, which she responded that the products were to be cooked for lunch. The provider stated that the food products had been obtained from a " friend ". The provider then stated that she would cook the meat product for the cat. The bag of meat looked to be approximately lbs. of meat. The bag of onions looked to be the approximate weight of 6-7 lbs. of cooked onions.

During an observation conducted on at approximately 10:10 a.m. of the sole kitchen refrigerator, revealed approximately 8 more large plastic grocery type bags with the unmarked meat product. The upright freezer located in the dry storage area was reviewed and found to have approximately 18 more large plastic grocery type bags with unmarked meat products. The provider was not able to provide documentation as to the source of the meat products.

During an observation conducted on at approximately 10:20 a.m. of a utility closet that

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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 092	Continued From page 9 was located off the dry goods storage area, revealed that the closet had multiple accumulations of miscellaneous boxes and junk stored in it. At the time of observation a pile of the plastic bags with the meat products had been placed in the closet, uncontained. Staff member B stated at this time he was going to throw the meat out. It could be determined that the provider was obtaining meat from an unknown source and potentially serving the meat during meals. It could also be determined that the provider was holding the meat at which could promote food borne illness. Class III Widespread	A 092		
A 152	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with	A 152		

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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 152	Continued From page 10 the top surface of the mattress a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, chest or other furniture designed for storage of personal effects; 4. A table, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested. (c) The facility must maintain master or duplicate keys to resident [redacted] to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be This Statute or Rule is not met as evidenced by: Based on observation, the facility failed to ensure that it maintained a safe and sanitary environment in regards to an unclean linen closet with insects present, in regards to uncleanliness of 2 of 2 sampled residential [redacted] and the presence of ants in one of the [redacted] ; in regards to an unorganized utility closet, inaccessible electric panel and water heater and uncontained melting meat products. Failing to maintain a safe and sanitary environment potentiates health hazards and unsafe conditions for residents residing in the facility. Findings include:	A 152		

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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 152	Continued From page 11 During the tour of the facility on [redacted] at 9:55 a.m. the following was observed: The linen closet that was located off the main dining area was stocked full of linens. The floor of the linen closet was observed and found to have a heavy accumulation of dust present. A water tank was present in the closet and observed to have heavy dust build up present on the top of the tank. The overhead fire sprinkler was observed to have 3-4 large noticeable spiders hanging and nesting on the sprinkler head. The top shelf of linens had brown spotting present on the linens. A residential [redacted], located off the main dining area had a noticeable heavy [redacted] smell present. Dark staining was present on the floor where the commode base met the tile flooring. Two small black ants were observed on the sink in the [redacted]. A [redacted] the back hallway had a missing light in the light fixture over the sink. A medium [redacted] odor was present in the [redacted], the tile floor around the commode base had heavy staining present which spread out from the base of the commode approximately 12 inches around the base. A utility closet that was located off of the dry goods storage area was observed to have multiple articles of junk and boxes present in it. At the time of observation, 10:20 a.m., the provider had placed a mound of multiple plastic grocery bags of meat products in the utility closet, these bags were uncontained, and the meat looked like it was thawing. The utility closet was observed to have an electric panel and a water heater present. Both the electric panel and the	A 152		

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
	AL11932571	A. BUILDING _____ B. WING _____	06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FEEL AT HOME, INC.	129 WEST 131ST AVENUE TAMPA, FL 33612

(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 152	Continued From page 12 water heater were inaccessible due to the amount of miscellaneous articles that were haphazardly placed in the . . . . . The electric panel on the west wall was observed to have heavy water damage present that extended approximately 3 feet to the right (height and width) of the panel. Class III	A 152		

RICK SCOTT
GOVERNOR

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Feel at Home, Inc.
129 West 131st Avenue
Tampa, FL 33612

Dear Administrator:

Re: Revisit & **CCR# 2012006511**

This letter reports the findings of a state licensure survey revisit and a complaint survey that was conducted on . . . . 26, 2012, by a representative of this office.

Attached is the provider's copy of the Revisit Report, which indicates the deficiencies were found corrected relative to the revisit, and the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit relative to the complaint survey. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: Revisit Report and State Form 3020

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161