

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 These are the results of a Biennial survey completed on _____ for Tina's ALF, an Assisted Living Facility. This was scheduled as an Abbreviated survey turned into a standard survey. Deficiencies were identified as follows:	A 000			
A 010	58A-5.0181(4) FAC Admissions - Continued Residency (4) CONTINUED RESIDENCY. Except as follows in paragraphs (a) through (e) of this subsection, criteria for continued residency in any licensed facility shall be the same as the criteria for admission. As part of the continued residency criteria, a resident must have a face-to-face medical examination by a licensed health care provider at least every 3 years after the initial assessment, or after a significant change, whichever comes first. A significant change is defined in Rule 58A-5.0131, F.A.C. The results of the examination must be recorded on AHCA Form 1823, which is incorporated by reference in paragraph (2)(b) of this rule. The form must be completed in accordance with that paragraph. After the effective date of this rule, providers shall have up to 12 months to comply with this requirement. (a) The resident may be bedridden for up to 7 consecutive days. (b) A resident requiring care of a stage sore _____ be retained provided that: 1. The facility has a LNS license and services are provided pursuant to a plan of care issued by a licensed health care provider, or the resident contracts directly with a licensed home health agency or a nurse to provide care; 2. The condition is documented in the resident 's record; and 3. If the resident 's condition fails to improve	A 010			

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

0890

XQWJ11

If continuation sheet 1 of 14

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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.010	Continued From page 1 within 30 days, as documented by a licensed health care provider, the resident shall be discharged from the facility. (c) A ill resident who no longer meets the criteria for continued residency may continue to reside in the facility if the following conditions are met: 1. The resident qualifies for, is admitted to, and consents to the services of a licensed hospice which coordinates and ensures the provision of any additional care and services that may be needed; 2. Continued residency is agreeable to the resident and the facility; 3. An interdisciplinary care plan is developed and implemented by a licensed hospice in consultation with the facility. Facility staff may provide any nursing service permitted under the facility's license and total help with the activities of daily living; and 4. Documentation of the requirements of this paragraph is maintained in the resident's file. (d) The administrator is responsible for monitoring the continued appropriateness of placement of a resident in the facility. (e) Continued residency criteria for facilities holding an extended congregate care license are described in Rule 58A-5.030, F.A.C. (5) DISCHARGE. If the resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or licensed health care provider, the resident shall be discharged in accordance with Section 429.28(1), F.S.	A.010			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 010	Continued From page 2 This Statute or Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure Hospice residents have a interdisciplinary care plan for the use of an O2 concentrator for 1 (Resident #5) of 4 residents receiving Hospice services. The finding include: - On _____ at 9:30 a.m., Resident #5 was observed to have O2 tubing running from the living _____ to the ceiling and through the house to the O2 concentrator sitting on the back patio. - Record review found that Resident #5 was receiving Hospice service. The record showed an order for O2 service was received on _____. The record had no interdisciplinary care plan addressing the provision of O2 service. - On _____ at 2:55 p.m. the Administrator stated she assists the resident with the air tubing running through the house. She stated if the O2 concentrator needs water she is the one that fills the water container. Class III	A 010			
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 030	Continued From page 3 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456. (d) The statewide toll-free telephone number of the Florida Hotline " 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents. (e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility's policies with respect to such issues, for example, as resident responsibilities, the facility's and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements. (f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 030	Continued From page 4 or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law. (g) The facility shall provide residents with convenient access to a telephone to facilitate the resident's right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical _____ shall be limited to half-bed rails, and only upon the written order of the resident's physician, who shall review the order biannually, and the consent of the resident or the resident's representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical _____. 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from _____ and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 CORRELATED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
A 030	Continued From page 5 personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for caregivers and out-of-town guests, and in other similar situations. (e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community. (f) Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27. (g) Share a _____ his or her spouse if both are residents of the facility. (h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather. (i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident. (j) Access to adequate and appropriate health care consistent with established and recognized standards within the community. (k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 030	Continued From page 6 physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally ill, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction. (i) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to honor resident rights to a homelike environment and care within community standards for 6 (Residents #1, #2, #3, #4, #5, and #6) of 6 residents reviewed. The findings include: 1. On _____ at 9:30 a.m. Residents #1, #3, #4, and #5 were observed to have their tubing running from the living room to the	A 030			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 030	Continued From page 7 ceiling and through out the house, and to the 4 O2 concentrators sitting on the back patio. The tubing for all 4 residents looped around the walls and passed through a hole in the wall of The tubing then passed down the and out to the patio through a hole in the was observed to have two beds. The occupied by Resident #3. 2. On at 11:30 a.m. the Administrator stated the concentrators for Residents #1, #3, #4, and #5 were set on the back patio because they were noisy. She has run the O2 tubing through the house so the residents had enough tubing to be able to walk throughout the house. She stated the second bed in is for daycare residents so when they need to take a nap they can have a place to lay down. She verified each of these concentrators had 3 lengths of 25 foot tubing running from the concentrators to the resident. 3. A telephone call to the provider revealed concentrators were to be used with no more than 50 feet of tubing. The concentration of is greatly diminished after 50 feet and the manufacturer sets 50 feet as the maximum limit of tubing. Class III	A 030			
A 081	58A-5.0191(2) FAC Training - Staff In-Service (2) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 081	Continued From page 8 (a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions, and facility sanitation procedures before providing personal care to residents. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to _____ borne _____ may be used to meet this requirement. (b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Reporting major incidents. 2. Reporting adverse incidents. 3. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident neglect, and (d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with Rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (e) Staff who prepare or serve food, who have not taken the assisted living facility core training must	A 081			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 081	Continued From page 9 receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices. (f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 (Staff #B) of 2 employees received all required training. The findings include: 1. Record review for Staff #B found no evidence of having received the required training in infection incident reporting, resident rights, and recognizing and reporting abuse. ... On 01/30 2:45 the administrator stated the verification of having received the required training was not available. Class III	A 081			
A 091	58A-5.0191(12) FAC Training - Documentation & Monitoring (12) TRAINING DOCUMENTATION AND	A 091			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 091	Continued From page 10 MONITORING. (a) Except as otherwise noted, certificates, or copies of certificates, of any training required by this rule must be documented in the facility's personnel files. The documentation must include the following: 1. The title of the training program; 2. The subject matter of the training program; 3. The training program agenda; 4. The number of hours of the training program; 5. The trainee's name, dates of participation, and location of the training program; 6. The training provider's name, dated signature and credentials, and professional license number, if applicable. (b) Upon successful completion of training pursuant to this rule, the training provider must issue a certificate to the trainee as specified in this rule. (c) The facility must provide the Department of Elder Affairs and the Agency for Health Care Administration with training documentation and training certificates for review, as requested. The department and agency reserve the right to attend and monitor all facility in-service training, which is intended to meet regulatory requirements. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 (Staff #B) of 2 employees received the required training in _____. The findings include: 1. Record review for Staff #B found no evidence of having received the required training in _____.	A 091			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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 091	Continued From page 11 2. On at 2:45 the administrator stated the verification of having received the required training was not available. Class III	A 091			
AZ827	408.812, FS Unlicensed Activity (1) A person or entity may not offer or advertise services that require licensure as defined by this part, authorizing statutes, or applicable rules to the public without obtaining a valid license from the agency. A licenseholder may not advertise or hold out to the public that he or she holds a license for other than that for which he or she actually holds the license. (2) The operation or maintenance of an unlicensed provider or the performance of any services that require licensure without proper licensure is a violation of this part and authorizing statutes. Unlicensed activity constitutes harm that materially affects the health, safety, and welfare of clients. The agency or any state attorney may, in addition to other remedies provided in this part, bring an action for an injunction to restrain such violation, or to enjoin the future operation or maintenance of the unlicensed provider or the performance of any services in violation of this part and authorizing statutes, until compliance with this part, authorizing statutes, and agency rules has been demonstrated to the satisfaction of the agency. (3) It is unlawful for any person or entity to own, operate, or maintain an unlicensed provider. If after receiving notification from the agency, such person or entity fails to cease operation and apply for a license under this part and authorizing	AZ827			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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
AZ827	Continued From page 12 statutes, the person or entity shall be subject to penalties as prescribed by authorizing statutes and applicable rules. Each day of continued operation is a separate offense. (4) Any person or entity that fails to cease operation after agency notification may be fined \$1,000 for each day of noncompliance. (5) When a controlling interest or licensee has an interest in more than one provider and fails to license a provider rendering services that require licensure, the agency may revoke all licenses and impose actions under s. 408.814 and a fine of \$1,000 per day, unless otherwise specified by authorizing statutes, against each licensee until such time as the appropriate license is obtained for the unlicensed operation. (6) In addition to granting injunctive relief pursuant to subsection (2), if the agency determines that a person or entity is operating or maintaining a provider without obtaining a license and determines that a condition exists that poses a threat to the health, safety, or welfare of a client of the provider, the person or entity is subject to the same actions and fines imposed against a licensee as specified in this part, authorizing statutes, and agency rules. (7) Any person aware of the operation of an unlicensed provider must report that provider to the agency. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to secure a Limited Nursing specialty license prior to assisting 4 (Residents #1, #3, #4, #5) of 6 resident with O2 services.	AZ827			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967574	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TINA'S ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 1172 TARPON AVE SARASOTA, FL 34237		
(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	
AZ827	Continued From page 13 The finding include: - On _____ at 9:30 a.m., Residents #1, #3, #4, and #5 were observed to have _____ tubing running from the cannula being used by each, around the living _____ to the ceiling and through the house and _____ to the 4 O2 concentrators sitting on the back patio. - On _____ at 9:30 a.m. the facility's license was observed hanging on the wall between the dining and living area. The facility has a Standard ALF license with no speciality. - On _____ at 2:55 p.m. the Administrator stated she assists the resident with the air tubing running through the house as residents move about the house. She stated that if the O2 concentrator needs water, she is the one that fills the water container. She further verified she is not a licensed nurse, nor does she have a Limited Nursing license. - Interview with Resident #3 on _____, when asked about the _____, stated, "I put this (cannula) on by myself. I do not handle anything else." (The resident was verifying she does not set the _____ flow nor fill the reservoir with water.) - Interview with Resident #4 on _____, when asked about the _____, stated, "They help me do all. I can put this (cannula) on, it's all I do with it." (The resident was verifying she does not set the _____ flow nor fill the reservoir with water.) Unclassified	AZ827			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Tina's ALF
1172 Tarpon Avenue
Sarasota, Florida 34237

Dear Administrator:

Re: Biennial survey

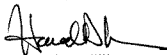
This letter reports the findings of a state licensure survey that was completed on . 2013 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit. 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 after . 2013 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 this office at 239-335-1315.

Sincerely,



Harold D. Williams
Field Office Manager

HW:ss
Enclosure: State Form

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



Fort Myers Field Office
2295 Victoria Avenue, . . .
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372