AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910045	R 02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAILES BOARDING HOME	**1009 N WILLOW TAMPA, FL 33607**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Assisted Living Facility

Amended

On , a second revisit to complaint survey (CCR# 2015000750) was conducted at Hailes Boarding Home Assisted Living Facility. Deficiencies were identified the day of survey.

Please note that the text for Tag A 0079 was modified administratively on .

0079 Staffing Standards - Levels

Based on interview and record review, the facility failed to maintain an up-to-date written work schedule. Specifically, the facility was not able to verify the current number of hours worked by staff and therefore could not meet the required 212 hours per week as required for the facility's current census.

Findings included:

On at 11:01 AM a review was conducted of the facility's staffing schedule for the period of 2/1- . There was no schedule available for review for . The schedule showed staff on Saturday from 8am-5pm, and 5pm-8pm. No one was scheduled to work from 6am-8am on Saturday morning. No one was scheduled from 8pm- 8am either on Saturday or Sunday.
On at 11:05 AM an interview was conducted with Staff A. Staff A stated there was no schedule for the day of survey. Staff A stated the schedule is the same and does not change. She provided the schedule she had previously prepared for 2/1/16- . Staff A stated she is scheduled on Monday through Friday from 6:00 PM until 6:00 AM. Staff A stated Staff G is scheduled Monday through Friday from 6:00 AM until 6:00 PM. Staff A stated Staff C is scheduled on Saturday and Sunday from 8:00 AM until 5:00 PM. Staff A stated Staff F is scheduled on Saturday and Sunday from 5:00 PM until 8:00 PM. Staff A stated usually Staff A or Staff G " fills in " for the hours that are not covered by the schedule. Staff A did not know how many hours she had scheduled per week. The current schedule shows 168 hours are scheduled. The schedule does not show adequate coverage for the current census of 11 residents. Staff A stated she would cover the 8:00 PM through 8:00 AM shift on Saturday and Sunday. Even with the addition of these 24 hours, the total remained at 192 hours, and therefore the staffing schedule did not meet the required hours of 212 hours for the current census of 11 residents.

Class III

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910045	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAILES BOARDING HOME	**1009 N WILLOW TAMPA, FL 33607**

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0083 Training - First Aid and

Based on interview and record review, the facility failed to ensure that 1 out of 4 (Staff A) sampled staff who are left alone with residents have current First Aid and ( ) training.

Findings included:

On at 11:12 AM a review was conducted of the employee file for Staff A. Staff A had received First Aid and training in 2011. The training expired 2013. Staff A had received on-line training in Basic First Aid on . The online training certificate stated it must be combined with a face-to-face verification of skills in order to receive the certification card. Staff A was previously cited for failure to have a current First Aid and ( ) training during a survey conducted on .
On at 11:12 AM an interview was conducted with Staff A. Staff A stated she had plans to take the First Aid and training on . Staff A admitted she was the only employee on the staffing schedule Monday through Friday from 6:00 PM through 6:00 AM. Staff A was aware that an employee with current First Aid and training must be on the schedule and in the facility at all times.

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11910045	A. Building B. Wing	Y2 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAILES BOARDING HOME	1009 N WILLOW TAMPA, FL 33607

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0078	Correction	ID Prefix A0081	Correction	ID Prefix A0084	Correction
Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed
LSC		LSC		LSC	
ID Prefix AZ815	Correction	ID Prefix AZ816	Correction	ID Prefix AZ827	Correction
Reg. # 408.809, 435.02(2), 435.06	Completed	Reg. # 408.809(2)(a-c) FS	Completed	Reg. # 408.812, FS	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	JB	2/24/16		
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 3/16/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: WEG513

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Hailes Boarding Home
1009 N Willow
Tampa, FL 33607

Re: **Amended Report**

Dear Administrator:

This letter reports the findings of a second state licensure revisit survey conducted on , 2016, by representative(s) of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies corrected during the visit, uncorrected deficiencies and/or new deficiencies that were identified on the day of the visit. Please be advised that the text for Tag A 0079 was modified administratively on .

All deficiencies shall be corrected no later than , 2016.

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(s). 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: State Form (5000-3547) & Revisit Report

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