STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967240	05/04/2016
NAME OF PROVIDER OR SUPPLIER **TORIA'S ASSISTED LIVING FACILITY II**	STREET ADDRESS, CITY, STATE, ZIP CODE **613 FOREST HILLS** **BRANDON, FL 33510**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

On , 2016 a biennial re-licensure survey was conducted at Toria's Assisted Living Facility II. Deficient practice was identified during the survey.

0078 Staffing Standards - Staff

Based on interview and record review, the facility failed to show evidence of a written statement from a health care provider documenting that staff had no signs or symptoms of a communicable , within 30 days of beginning employment (Communicable Statements), for 2 (Staff B and Staff C) of 4 employee records reviewed. Additionally, the facility failed to maintain proof of annual, negative examinations (Exams) for 2 (Staff A and Staff C) of 4 employee records reviewed.

Findings included:

A review of employee records conducted on showed that Staff A had a date of hire of , Staff B had a date of hire of / and Staff C had a date of hire of .

Reviews of Staff B ' s and Staff C ' s records showed a lack of evidence of Communicable Statements. Additionally, the record review showed a lack of proof of Tests for Staff A and Staff C.

The manager was interviewed at 3:32 PM on and she stated that she wasn ' t able to locate the missing Communicable Statements and Exams for Staff A, Staff B, and Staff C.

Class III

0093 Food Service - Dietary Standards

Based on observation, interview, and record review, the facility failed to show proof of a 6 month substitution log or a 6 month file of dated menus. Additionally, the facility failed to maintain an adequate supply of water to be utilized in the event of an emergency.
Findings included:
A dining and food service review was conducted on . The manager was asked to present the facility ' s 6 month substitution log and a file of 6 months of dated menus.
At 11:56 AM on , the manager stated that there was no file of dated menus.
A review of the substitution log on showed that it dated back only to . At 12:26 PM on

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, the manager was interviewed concerning the lack of entries on the substitution log and she acknowledged that that was all that the staff had noted.
An observation of the facility ' s 3 day emergency supply of water on showed 13 gallons of water present, lacking the minimum requirement of 21 gallons.
The manager was interviewed at 12:48 PM on concerning the 3 day emergency supply of water and she stated that that was all they had.

Class III

Z814 Background Screening Clearinghouse

Based on interview and record review, the facility failed to maintain the employment status of all employees within the background screening clearinghouse (Clearinghouse) within 10 business days of initial employment status for 4 (Administrator, Staff A, Staff B, and Staff C) of 4 employees reviewed.
Findings included:
A review of the facility ' s employee roster in the Clearinghouse was conducted on at 10:44 AM. The review showed that there were no entries in to the employee roster.
A review of employee records conducted on showed that the administrator had a date of hire of 2013, Staff A had a date of hire of , Staff B had a date of hire of / , and Staff C had a date of hire of .
An interview was conducted with the manager at 10:37 AM on and she was asked for a copy of the employee roster from the Clearinghouse. At 10:49 AM on , the manager stated that she didn ' t believe it was done.
A review of staff files indicate that the level II Back Ground Screenings were: Administrator eligible , Staff A was eligible , Staff B was eligible / and Staff C was eligible .

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Toria's Assisted Living Facility II
613 Forest Hills
Brandon, FL 33510

Dear Administrator:

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

Attached is the provider's copy of the State (5000-3547) 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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.

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Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Teresa Ryan**, RNC, at 727-552-2000.

Sincerely,

Patricia Reid Caulfman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90