AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967351	**05/16/2016**
NAME OF PROVIDER OR SUPPLIER **TORIA'S ASSISTED LIVING FACILITY I**	STREET ADDRESS, CITY, STATE, ZIP CODE **2073 BALFOUR CIRCLE TAMPA, FL 33619**	

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

0000 Initial Comments

Assisted Living Facility

A complaint investigation (CCR #2016002480) was conducted at Toria's Assisted Living Facility I on 16, 2016. Toria's Assisted Living Facility I had a deficiency at the time of the visit.

0167 Resident Contracts

Based on record review and interview, four of six residents sampled (#1;4;5;6) did not have a valid contract in place,while two of six residents (#2;3) had a questionable monthly rate stipulated.

Findings included:

A review of resident records during the investigation revealed the following concerns:

a) Resident #1 was admitted to the facility . Review of this individual's contract found a document that had not been signed by either the resident/resident's representative on the Agreement page (pg. 28), had no signatures from the resident/representative and the administrator/other facility representative on the financial agreement section (p. 20), contained no signatures/initials from either party (facility or resident) on the "resident/responsible party agree to..." section, and was missing formal signatures on several facility policies including unused medications, smoking, beneficiary designation, and bedhold;

b) Resident #4 was admitted to the facility . Further review of the file found no contract in place. Interview with the Program Operations Manager of the facility's management organization at 1:10pm on indicated that "the administration thought this document was only required within 30 days of admission;"

c) Resident #5 was admitted . Review of this resident's contract revealed an agreement that was missing the resident's or the resident representative's signature on p. 28 (the entire agreement page), there was no financial agreement section pg. available for review, and several policies had not been signed by the resident, including the facility's personal items policy, permission to treat/be moved in an emergency, and general rules of the house; and

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d) Resident #6 was admitted to the facility . . /. .. A review of the resident's contract indicated that the financial agreement section (p. 20) had not been signed by a facility representative, while neither the resident/their representative nor an ALF staff person had signed the "resident/responsible party agree to" page. In addition, virtually none of the facility policies and procedures had been signed by the resident/their representative and an ALF staff representative.

Review of the contracts for Residents #2 and 3 (hired . . . and . . . , respectively), revealed a residency agreement from . . . . for Resident #2 stipulating a monthly charge of $644.80 and a agreement for Resident #3 indicating a monthly rate of $594. According to the Program Operations Manager, she was not sure what the new rates were for these residents.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Toria's Assisted Living Facility I
2073 Balfour Circle
Tampa, FL 33619

RE: CCR# 2016002480

Dear Administrator:

This letter reports the findings of a complaint 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 deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 the identified deficiency. 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 deficiency 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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Youtube.com/AHCAFlorida
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SlideShare.net/AHCAFlorida

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

Enclosure: State Form (5000-3547)

XG90