AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967351	R 09/14/2016
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 revisit to a biennial state licensure survey was conducted at Toria's Assisted Living Facility I (Lic. # 11393) on . Toria's Assisted Living Facility I had an uncorrected deficiency at the time of the visit.

0167 Resident Contracts

Based on record review and interview, the facility still had not amended its contract with respect to three of three residents sampled (#1;2 and 3).

Findings included:

A review of the contracts for three residents during the revisit found that these documents were still missing the following items:
a) there was still no verbiage/provision indicating that the facility was required to provide the resident/their responsible party with at least 30 days written notice of any increase in rent;
b) it did not contain the facility' policy/procedure related to a properly executed (); and
c) there was no provision indicating that residents must be assessed upon admission and every 3 years thereafter, or after a significant change.

Interview with administrative staff at 11:45am on confirmed that the administrator had been working on the corrections and they thought she had completed them.

(Please Note: This is an uncorrected deficiency from the biennial survey).
Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11967351 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TORIA'S ASSISTED LIVING FACILITY I	2073 BALFOUR CIRCLE TAMPA, FL 33619

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 A0008	Correction	ID Prefix A0082	Correction	ID Prefix A0083	Correction
Reg. # 429.26(4-6) FS; 58A-5.0181(2) FAC	Completed	Reg. # 58A-5.0191(3) FAC	Completed	Reg. # 58A-5.0191(4) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0084	Correction	ID Prefix AZ814	Correction	ID Prefix AZ815	Correction
Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 435.12(2)(b-d), FS	Completed	Reg. # 408.809, 435.02(2), 435.06	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) PJB	DATE 9/20/16	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
7/25/2016	

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a state Licensure Revisit Survey conducted on
14, 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, and the uncorrected deficiency that was identified on the day of the visit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. The **deficiency 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

Enclosure: State Form 5000-3547

YOSF

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com