| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11942892** | **06/08/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**TAMPA LIVING CARE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**11722 NORTH 17TH STREET**<br>**TAMPA, FL 33612** | |

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

**0000 - Initial Comments**

Assisted Living Facility

A complaint investigation, (CCR# 2017002765), was conducted at Tampa Living Care, (formerly known as Sunrise Senior Village Assisted Living), on . Tampa Living Care had deficiencies at the time of the investigation.

(License #5898)

**0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC**

Based on interview and record review, the facility failed to notify the resident's family of discharge and move out for one (Resident #1) of three records reviewed.

Findings included:

A review of the facility's admission/discharge log indicated that Resident #1 was discharged from the facility on . A review of Resident #1's record showed a General Power of Attorney (POA) document dated (photographic evidence obtained). A review of Resident #1's record did not show a 45-day notice of discharge (Discharge Notice) to Resident #1's POA.

A phone interview was conducted with Resident #1's POA at 11:35 AM on . The POA stated that they never received a Discharge Notice for Resident #1 and was not notified of the discharge until about a month later.

The Administrator was interviewed at 1:20 PM and they stated that, if a resident has a POA, the Discharge Notice would go to them and sometimes the resident. When asked why Resident #1's POA did not receive a 45-day notice, they stated that they had no answer. The Administrator stated that they agreed that the POA had a right to know about the discharge and should have received a 45 day notice of the discharge. There was no proof provided that the facility had attempted to reach family members prior to Resident #1's discharge.

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SUMMARY STATEMENT OF DEFICIENCIES
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Class III

**0091 - Training - Documentation & Monitoring - 58A-5.0191(12) FAC**

Based on interview and record review, the facility failed to provide training documentation that included dates of participation in in-service training for one (Staff C) of three employee records reviewed.

Findings included:

A focused employee record review was conducted on . A review of Staff C's employee record showed a date of hire of . A review of Staff C's training certificate in the topic of resident rights/ recognizing and reporting , neglect and , (Resident Rights Training) showed no date for this training.

An interview was conducted with the Administrator at 1:34 PM on concerning the lack of the date of participation for Staff C's Resident Rights Training. The Administrator acknowledged that there was no date documented for the training.

Class III

**0160 - Records - Facility - 58A-5.024(1) FAC**

Based on interview and record review, the facility to maintain an admission and discharge log that included the reasons for discharge for three (Residents #1, #2, and #3) of 3 resident records sampled.

Findings included:

A review of the facility's admission and discharge log conducted on showed the following discharges: Resident #1: date of discharge: ; Resident #2: date of discharge: ; Resident #3: date of discharge: . The review of the admission/discharge log showed no reasons as to why Residents #1, #2, and #3 were discharged from the facility.

An interview was conducted with the Administrator at 1:39 PM on . The Administrator acknowledged that there were no reasons listed on the admission/discharge log as to why Residents #1,

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

#2, and #3 were discharged from the facility.

Class III

**0162 - Records - Resident - 58A-5.024(3) FAC**

Based on interview and record review the facility failed to provide a resident's contract for one (#2) out of four resident records reviewed.

Findings included:

On , a closed record review was completed for resident #2 who was admitted to the facility on . The resident was discharged from the facility to another assisted living facility on .

A contract entitled Lease Agreement from another facility owned by the same entity was in the resident's record and was dated . The resident was then admitted to Tampa Living Care Assisted Living on .

At 12:05 PM on , an interview was conducted with the Administrator. The Administrator was unable to locate a contract for the resident within the facility. She then called and spoke on the telephone several times, with whom she identified as the Regional Administrator. The Administrator stated that the Regional was trying to send an addendum from the original contract from when he had lived at the other sister facility. At 12:28 PM, she confirmed that there was no contract for the resident for Tampa Living Care in her system or in the facility.

Class III