

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 02/28/2019
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968783	(X3) DATE SURVEY COMPLETED 02/12/2019
NAME OF PROVIDER OR SUPPLIER ARBOR TERRACE AT CITRUS PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 13810 SHELDON RD TAMPA, FL 33626	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)		
0000 - Initial Comments Assisted Living Facility A complaint investigation (CCR# 2018017816) was conducted on at Arbor Terrace at Citrus Park (License # 12657) an Assisted Living Facility in Tampa, FL. There were deficiencies identified at the time of survey. 0081 - Training - Staff In-Service - 58A-5.0191() FAC Based on interview and employee record review, the facility failed to ensure 3 of 4 (Staff A, Staff B, and Staff C) staff received Assisting with Daily Living (ADLs) and Behavioral needs training within 30 days of employment, for staff who provide direct care to residents. Findings Included: Focused employee record review conducted on revealed Staff A with a date of hire of was missing ADL and Behavioral needs training in their employee file. Focused employee record review conducted on revealed Staff B with a date of hire of was missing ADL and Behavioral needs training in their employee file. Focused employee record review conducted on revealed Staff C with a date of hire of was missing ADL and Behavioral needs training in their employee file. An interview was conducted on at 2:32pm with the Business Office Manager. The Business Office Manager reviewed the employees files and confirmed the missing required training. Class III 0152 - Physical Plant - Safe Living Environ/Other - 58A-5.023(3) FAC Based on observation and interview, the facility failed to assure that mechanical systems (resident emergency call lights) was working properly. Findings Included:		

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An interview conducted with the Administrator on 02/12/2019 at 10:12am revealed there was no set time in which staff should be responding to the emergency call system. If the alert is not answered by a staff within 10 minutes, it alerts the front desk and the person at the front desk follows up. The emergency call system was pushed in the sitting room of 13810 Sheldon Rd. There were no staff that responded to the call light by 11:10am. An interview was conducted on 02/12/2019 at 11:10am with the Resident Care Director (RCD). The RCD revealed there was no alert on the pager for 13810 Sheldon Rd. The RCD went to speak to the receptionist and asked if there was an alert for 13810 Sheldon Rd, and the receptionist stated no. The emergency call system was pushed on 02/12/2019 at 11:15am by the RCD in the bedroom and the sitting room in 13810 Sheldon Rd and there were no alerts on the pager. The RCD and Memory Care Supervisor walked in and pulled the cord in the bathroom of 13810 Sheldon Rd and it alerted the pager immediately. After about 3 minutes of pulling the cord in the bathroom, the pager alerted that the emergency call light had been pushed for the sitting room in 13810 Sheldon Rd. An interview was conducted on 02/12/2019 at 11:18am with the RCD. The RCD confirmed the emergency call system was not working properly. Class III		