

Agency for Health Care Administration

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|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967974</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/06/2019</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**CAREGIVERS TOUCH ALF 2**

**7525 N CAMERON AVE  
TAMPA, FL 33614**

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |
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| A 000                    | Initial Comments<br><br>On a monitoring visit for compliance with generator and CEMP was conducted at Caregivers Touch ALF in Tampa, Florida. There were deficiencies identified at the time of survey.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | A 000               |                                                                                                                          |                          |
| A 181<br>SS=D            | 58A-5.026(2) FAC Emergency Plan Approval<br><br>(2) EMERGENCY PLAN APPROVAL. The plan must be submitted for review and approval to the local emergency management agency.<br>(a) If the local emergency management agency requires revisions to the emergency management plan, such revisions must be made and the plan resubmitted to the local office within 30 days of receiving notification that the plan must be revised.<br>(b) A new facility as described in Rule 58A-5.023, F.A.C., and facilities whose ownership has been transferred, must submit an emergency management plan within 30 days after obtaining a license.<br>(c) The facility must review its emergency management plan on an annual basis. Any substantive changes must be submitted to the local emergency agency for review and approval.<br>1. Changes in the name, address, telephone number, or position of staff listed in the plan are not considered substantive revisions for the purposes of this rule.<br>2. Changes in the identification of specific staff must be submitted to the local emergency management agency annually as a signed and dated addendum that is not subject to review and approval.<br>(d) The local emergency management agency is the final administrative authority for emergency management plans prepared by assisted living facilities.<br>(e) Any plan approved by the local emergency | A 181               |                                                                                                                          |                          |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                        |
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| A 181                    | <p>Continued From page 1</p> <p>management agency is considered to have met all the criteria and conditions established in this rule.</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview the facility failed to submit their Emergency Management Plan for approval to their local emergency management agency.</p> <p>Findings Included</p> <p>On during a monitoring visit it was revealed that the last time the facility had updated and submitted their emergency plan for approval was . . . . . The plan did not include facility's plan for the residents who must be evacuated how they would be transported and where they would be evacuated.</p> <p>During an interview with Staff A on at 10:00am, he stated they were in the process of updating the plan before it could be submitted.</p> <p>Class III</p> | A 181               |                                                                                                                          |                          |