

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>AL11965107</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/19/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TAMPA GARDENS SENIOR LIVING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>16702 NORTH DALE MABRY<br/>TAMPA, FL 33618</b>                               |  |                                                        |
| (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                               |
| A 000                                                                  | Initial Comments<br><br>A change of ownership survey and an Extended<br>Congregate Care (ECC) survey was conducted at<br>Tampa Gardens Senior Living on .<br>The provider had deficiencies at the time of the<br>visit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | A 000                                                                          |                                                                                                                          |  |                                                        |
| A 081<br>SS=D                                                          | 429.52(1 & 7) FS; 59A-36.011( ) FAC Training<br>- Staff In-Service<br><br>429.52(1)<br>(1) Each new assisted living facility employee who<br>has not previously completed core training must<br>attend a preservice orientation provided by the<br>facility before interacting with residents. The<br>preservice orientation must be at least 2 hours in<br>duration and cover topics that help the employee<br>provide responsible care and respond to the<br>needs of facility residents. Upon completion, the<br>employee and the administrator of the facility<br>must sign a statement that the employee<br>completed the required preservice orientation.<br>The facility must keep the signed statement in the<br>employee's personnel record.<br><br>(7) Facility staff shall participate in inservice<br>training relevant to their job duties as specified by<br>agency rule. Topics covered during the preservice<br>orientation are not required to be repeated during<br>inservice training. A single certificate of<br>completion that covers all required inservice<br>training topics may be issued to a participating<br>staff member if the training is provided in a single<br>training course.<br><br>59A-36.011<br>(2) STAFF PRESERVICE ORIENTATION.<br>(a) Facilities must provide a preservice<br>orientation of at least 2 hours to all new assisted<br>living facility employees who have not previously | A 081                                                                          |                                                                                                                          |  |                                                        |

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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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TAMPA GARDENS SENIOR LIVING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>16702 NORTH DALE MABRY<br/>TAMPA, FL 33618</b>                               |  |                                                        |
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| A 081                                                                  | Continued From page 1<br><br>completed core training as detailed in subsection (1).<br>(b) New staff must complete the preservice orientation prior to interacting with residents.<br>(c) Once complete, the employee and the facility administrator must sign a statement that the employee completed the preservice orientation which must be kept in the employee's personnel record.<br>(d) In addition to topics that may be chosen by the facility administrator, the preservice orientation must cover:<br>1. Resident's rights; and,<br>2. The facility's license type and services offered by the facility.<br>(3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff:<br>(a) Staff who provide direct care to residents, other than nurses, certified nursing assistants, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive a minimum of 1 hour in-service training in control, including universal precautions and facility sanitation procedures, before providing personal care to residents. The facility must use its control policies and procedures when offering this training. Documentation of compliance with the staff training requirements of 29 CFR 1910.1030, relating to blood borne pathogens, may be used to meet this requirement.<br>(b) Staff who provide direct care to residents must receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:<br>1. Reporting adverse incidents.<br>2. Facility emergency procedures including | A 081                                                                          |                                                                                                                          |  |                                                        |

Agency for Health Care Administration

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| A 081                                                                  | <p>Continued From page 2</p> <p>chain-of-command and staff roles relating to emergency evacuation.</p> <p>(c) Staff who provide direct care to residents, who have not taken the core training program, shall receive a minimum of 1 hour in-service training within 30 days of employment that covers the following subjects:</p> <ol style="list-style-type: none"> <li>1. Resident rights in an assisted living facility.</li> <li>2. Recognizing and reporting resident . . . . . neglect, and . . . . . The facility must use its . . . . . prevention policies and procedures when offering this training.</li> </ol> <p>(d) Staff who provide direct care to residents, other than nurses, CNAs, or home health aides trained in accordance with rule 59A-8.0095, F.A.C., must receive 3 hours of in-service training within 30 days of employment that covers the following subjects:</p> <ol style="list-style-type: none"> <li>1. Resident behavior and needs.</li> <li>2. Providing assistance with the activities of daily living.</li> </ol> <p>(e) Staff who prepare or serve food, who have not taken the assisted living facility core training must receive a minimum of 1-hour-in-service training within 30 days of employment in safe food handling practices.</p> <p>(f) All facility staff shall receive in-service training regarding the facility's resident elopement response policies and procedures within thirty (30) days of employment.</p> <ol style="list-style-type: none"> <li>1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures.</li> <li>2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures.</li> </ol> | A 081                                                                          |                                                                                                                          |                          |                                                        |

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TAMPA GARDENS SENIOR LIVING**

**16702 NORTH DALE MABRY  
TAMPA, FL 33618**

| (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 |
|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|
| A 081                    | <p>Continued From page 3</p> <p>This Statute or Rule is not met as evidenced by:<br/>Based on record review and interview, facility failed to ensure that one (Staff G) of five records sampled had evidence of the 2-hour required training for pre-service orientation prior to interacting with the residents.</p> <p>Findings include:</p> <p>Review of staff records conducted on revealed Staff G hired on . . . /2021 did not contain evidence of pre-service orientation training.</p> <p>In an interview with the Administrator on at 04:10 pm, she stated "I'm sure she has had it but, we do not have access to the old records anymore."</p> <p>Class III</p> | A 081               |                                                                                                                          |                          |
| A 162<br>SS=D            | <p>59A-36.015(3) FAC Records - Resident</p> <p>(3) RESIDENT RECORDS. Resident records must be maintained on the premises and include:</p> <p>(a) Resident demographic data as follows:</p> <ol style="list-style-type: none"> <li>1. Name,</li> <li>2. ,</li> <li>3. Race,</li> <li>4. Date of birth,</li> <li>5. Place of birth, if known,</li> <li>6. Social security number,</li> <li>7. Medicaid and/or Medicare number, or name of other health insurance ,</li> <li>8. Name, address, and telephone number of next of kin, legal representative, or individual designated by the resident for notification in case</li> </ol>                                       | A 162               |                                                                                                                          |                          |

Agency for Health Care Administration

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| A 162                                                                  | Continued From page 4<br><br>of an emergency; and,<br>9. Name, address, and telephone number of the health care provider and case manager, if applicable.<br>(b) A copy of the Resident Health Assessment form, AHCA Form 1823 described in rule 59A-36.006, F.A.C.<br>(c) Any orders for medications, nursing services, therapeutic diets, _____, or other services to be provided, supervised, or implemented by the facility that require a health care provider's order.<br>(d) Documentation of a resident's refusal of a therapeutic diet pursuant to rule 59A-36.012, F.A.C., if applicable.<br>(e) The resident care record described in paragraph 59A-36.007(1)(e), F.A.C.<br>(f) A _____ record that is initiated on admission. Information may be taken from AHCA Form 1823 or the resident's health assessment. Residents receiving assistance with the activities of daily living must have their _____ recorded semi-annually.<br>(g) For facilities that will have unlicensed staff assisting the resident with the self-administration of medication, a copy of the written informed consent described in rule 59A-36.006, F.A.C., if such consent is not included in the resident's contract.<br>(h) For facilities that manage a pill organizer, assist with self-administration of medications or administer medications for a resident, copies of the required medication records maintained pursuant to rule 59A-36.008, F.A.C.<br>(i) A copy of the resident's contract with the facility, including any addendums to the contract as described in rule 59A-36.018, F.A.C.<br>(j) For a facility whose owner, administrator, staff, or representative thereof, serves as an attorney in | A 162                                                                          |                                                                                                                          |                          |                                                        |

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STREET ADDRESS, CITY, STATE, ZIP CODE

**TAMPA GARDENS SENIOR LIVING**

**16702 NORTH DALE MABRY  
TAMPA, FL 33618**

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| A 162                    | <p>Continued From page 5</p> <p>fact for a resident, a copy of the monthly written statement of any transaction made on behalf of the resident as required in section 429.27, F.S.</p> <p>(k) For any facility that maintains a separate trust fund to receive funds or other property belonging to or due a resident, a copy of the quarterly written statement of funds or other property disbursed as required in section 429.27, F.S.</p> <p>(l) If the resident is an _____ recipient, a copy of the Department of Children and Families form Alternate Care Certification for _____ (____), CF-ES 1006, _____, which is hereby incorporated by reference and available for review at: <a href="http://www.flrules.org/Gateway/reference.asp?No=Ref-04004">http://www.flrules.org/Gateway/reference.asp?No=Ref-04004</a>. The absence of this form will not be the basis for administrative action against a facility if the facility can demonstrate that it has made a good faith effort to obtain the required documentation from the Department of Children and Families.</p> <p>(m) Documentation of the _____ of a health care surrogate, health care proxy, guardian, or the existence of a power of attorney, where applicable.</p> <p>(n) For hospice patients, the interdisciplinary care plan and other documentation that the resident is a hospice patient as required in rule 59A-36.006, F.A.C.</p> <p>(o) The resident's _____, DH Form 1896, if applicable.</p> <p>(p) For independent living residents who receive meals and occupy beds included within the licensed capacity of an assisted living facility, but who are not receiving any personal, limited nursing, or extended congregate care services, record keeping may be limited to the following at the discretion of the facility:</p> <p>1. A log listing the names of residents</p> | A 162               |                                                                                                                          |                          |

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| A 162                                                                  | <p>Continued From page 6</p> <p>participating in this arrangement.</p> <p>2. The resident demographic data required in this paragraph.</p> <p>3. The health assessment described in rule 59A-36.006, F.A.C.,</p> <p>4. The resident's contract described in rule 59A-36.018, F.A.C.; and,</p> <p>5. A health care provider's order for a therapeutic diet if such diet is prescribed and the resident participates in the meal plan offered by the facility.</p> <p>(q) Except for resident contracts, which must be retained for 5 years, all resident records must be retained for 2 years following the departure of a resident from the facility unless it is required by contract to retain the records for a longer period of time. Upon request, residents must be provided with a copy of their records upon departure from the facility.</p> <p>(r) Additional resident records requirements for facilities holding a limited mental health, extended congregate care, or limited nursing services license are provided in rules 59A-36.020, 59A-36.021 and 59A-36.022, F.A.C., respectively.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to weigh residents receiving assistance with Activities of daily living (ADL) semiannually for two (Resident #8 and #10) of two sampled.</p> <p>Finding included:</p> <p>A review of Health Assessments 1823 conducted on _____ revealed no semiannual _____ taken for Residents # 8 or #10.</p> <p>Interview conducted on _____ at 2:33pm with _____</p> | A 162                                                                          |                                                                                                                          |                          |                                                        |

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**TAMPA GARDENS SENIOR LIVING**

**16702 NORTH DALE MABRY  
TAMPA, FL 33618**

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| A 162                    | Continued From page 7<br><br>Executive Wellness Nurse she stated we do not have anything on residents prior to<br><br>Class III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | A 162               |                                                                                                                          |                          |
| AE206<br>SS=D            | 59A-36.021(6) FAC ECC - Service Plans<br><br>(6) SERVICE PLANS.<br>(a) Before receiving services, the extended congregate care administrator or manager must develop a preliminary service plan that includes an assessment of whether the resident meets the facility's residency criteria, an appraisal of the resident's unique physical, , , and social needs and preferences, and an evaluation of the facility's ability to meet the resident's needs.<br>(b) Within 14 days of receiving services, the extended congregate care administrator or manager must coordinate the development of a written service plan that takes into account the resident's health assessment obtained pursuant to subsection (6); the resident's unique physical, , , and social needs and preferences; and how the facility will meet the resident's needs including the following if required:<br>1. Health monitoring,<br>2. Assistance with personal care services,<br>3. Nursing services,<br>4. Supervision,<br>5. Special diets,<br>6. Ancillary services,<br>7. The provision of other services such as transportation and supportive services; and,<br>8. The manner of service provision, and identification of service providers, including family and friends, in keeping with resident preferences.<br>(c) Pursuant to the definitions of "shared responsibility" and "managed risk" as provided in | AE206               |                                                                                                                          |                          |

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>AL11965107</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/19/2021</b> |
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**TAMPA GARDENS SENIOR LIVING**

**16702 NORTH DALE MABRY  
TAMPA, FL 33618**

| (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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| AE206                    | <p>Continued From page 8</p> <p>section 429.02, F.S., the service plan must be developed and agreed upon by the resident or the resident's representative or designee, surrogate, guardian, or attorney-in-fact, and must reflect the responsibility and right of the resident to consider options and assume risks when making choices pertaining to the resident's service needs and preferences.</p> <p>(d) The service plan must be reviewed and updated quarterly to reflect any changes in the manner of service provision, accommodate any changes in the resident's physical or mental status, or pursuant to recommendations for modifications in the resident's care as documented in the nursing assessment.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide Quarterly Extended Congregate community service plan updates for two (Residents #8 and #9) of two residents sampled.</p> <p>Finding included:</p> <p>A review of the facility's Extended Congregate Care (ECC) binder revealed there was no evidence of Quarterly Extended Congregate community service plan updates for Residents #8 and #9</p> <p>Interview conducted on . . . . . at 1:30 p.m. with Wellness Nurse, she stated they do not have access to the quarterly assessments available.</p> <p>Class III</p> | AE206               |                                                                                                                          |                          |

Agency for Health Care Administration

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| CZ830<br>SS=D            | <p>408.821 FS Emergency Management Planning</p> <p>408.821 Emergency management planning; emergency operations; inactive license.-</p> <p>(1) A licensee required by authorizing statutes and agency rule to have a comprehensive emergency management plan must designate a safety liaison to serve as the primary contact for emergency operations. Such licensee shall submit its comprehensive emergency management plan to the local emergency management agency, county health department, or Department of Health as follows:</p> <p>(a) Submit the plan within 30 days after initial licensure and change of ownership, and notify the agency within 30 days after submission of the plan.</p> <p>(b) Submit the plan annually and within 30 days after any significant modification, as defined by agency rule, to a previously approved plan.</p> <p>(c) Submit necessary plan revisions within 30 days after notification that plan revisions are required.</p> <p>(d) Notify the agency within 30 days after approval of its plan by the local emergency management agency, county health department, or Department of Health.</p> <p>(2) An entity subject to this part may temporarily exceed its licensed capacity to act as a receiving provider in accordance with an approved comprehensive emergency management plan for up to 15 days. While in an overcapacity status, each provider must furnish or arrange for appropriate care and services to all clients. In addition, the agency may approve requests for overcapacity in excess of 15 days, which approvals may be based upon satisfactory justification and need as provided by the receiving and sending providers.</p> <p>(3)(a) An inactive license may be issued to a licensee subject to this section when the provider</p> | CZ830               |                                                                                                                          |                          |

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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| CZ830                    | <p>Continued From page 1</p> <p>is located in a geographic area in which a state of emergency was declared by the Governor if the provider:</p> <ol style="list-style-type: none"> <li>1. Suffered damage to its operation during the state of emergency.</li> <li>2. Is currently licensed.</li> <li>3. Does not have a provisional license.</li> <li>4. Will be temporarily unable to provide services but is reasonably expected to resume services within 12 months.</li> </ol> <p>(b) An inactive license may be issued for a period not to exceed 12 months but may be renewed by the agency for up to 12 additional months upon demonstration to the agency of progress toward reopening. A request by a licensee for an inactive license or to extend the previously approved inactive period must be submitted in writing to the agency, accompanied by written justification for the inactive license, which states the beginning and ending dates of inactivity and includes a plan for the transfer of any clients to other providers and appropriate licensure fees. Upon agency approval, the licensee shall notify clients of any necessary discharge or transfer as required by authorizing statutes or applicable rules. The beginning of the inactive licensure period shall be the date the provider ceases operations. The end of the inactive period shall become the license expiration date, and all licensure fees must be current, must be paid in full, and may be prorated. Reactivation of an inactive license requires the prior approval by the agency of a renewal application, including payment of licensure fees and agency inspections indicating compliance with all requirements of this part and applicable rules and statutes.</p> <p>(4) . . . Licensees providing residential or inpatient services must utilize an online database</p> | CZ830               |                                                                                                                          |                          |

Agency for Health Care Administration

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| CZ830                    | <p>Continued From page 2</p> <p>approved by the agency to report information to the agency regarding the provider's emergency status, planning, or operations.</p> <p>This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit their Comprehensive Emergency Management Plan within 30 days of a change of ownership (CHOW).</p> <p>Finding included:</p> <p>A review of the facility CHOW application conducted on _____ revealed a facility application dated _____ with a proposed change of ownership effective date of _____.</p> <p>A review of the facility's license conducted on _____ revealed the facility had a provisional license effective date of _____.</p> <p>A facility record review conducted on _____ revealed the facility's approved Comprehensive Emergency Management Plan (CEMP) was dated _____ and issued to the former facility owners.</p> <p>An interview conducted on _____ at 4:30pm with the Administrator revealed the CEMP approval letter issued to the prior facility was the most current CEMP on file.</p> <p>Unclassified</p> | CZ830               |                                                                                                                          |                          |