

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/13/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SUNNY VISTA ASSISTED LIVING FACILITY LLC

**8112 N 9TH ST
TAMPA, FL 33604**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments A complaint investigation (complaint #2023003874) was conducted at Sunny Vista Assisted Living Facility on Deficiencies were identified at the time of survey.	A 000		
A 025 SS=J	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule	A 025		

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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A 025	Continued From page 1 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide appropriate supervision and monitoring for safe smoking practices for 1 (Resident #1) of 7 sampled residents that smoked. The facility's failure to establish smoking policies and procedures resulted in a fire that placed all facility residents at risk of harm and the severe injury of one (Resident #1) resident. Finding included: An observation was conducted on _____ at 9:05 a.m., Resident #3 was observed on the patio with a lighter and cigarettes in _____. Resident #3	A 025			

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A 025	Continued From page 2 then dropped the lighter and struggled to pick it up. There was no fire extinguisher or fire blanket in sight. No facility staff were observed on the outside patio during the observation. An observation conducted on _____ at 9:10 a.m. revealed the facility was composed of three buildings with two living quarters that were approximately 8 meters apart separated by a parking lot. Building #1 (main building) contained the office, resident rooms for more dependent residents, living room, restroom, a dining room and outdoor porch. Building #2 was adjacent to the main building and was composed of the kitchen. Building #3 was across the parking lot from Building #1 and Building #2 contained bedrooms for the more independent residents, rest room, living room and outdoor porch. An observation conducted on _____ at 9:34 a.m. revealed various cigarette butts on the ground outside in the patio area of the buildings (photographic evidence obtained). A record review conducted on _____ of resident observation log signed off by the Administrator revealed on _____ at 8:45 a.m. Resident #1 picked up a cigarette butt from the floor and lit the cigarette while on _____ Resident #1's _____ and _____ caught on fire and first aid was given. The observation log also stated Resident #1 refused to go to the emergency room. On _____ a record review of the facility's self-reported document dated _____ revealed Resident #1 caught on fire, was provided first aid but the resident refused to go to the hospital. Physician ordered to wash the _____ everyday with mild soap and water, apply Ascend Silver	A 025			

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A 025	Continued From page 3 twice a day and start oral care was notified and scheduled for at 9:00 a.m. Care RN (Registered Nurse) came to the facility and decided resident needed to go to the emergency room for extended care. Administrator took Resident #1 to a local hospital. During an interview conducted on at 9:32 a.m. with local law enforcement, the officer stated that law enforcement visited the facility on due to an elderly neglect report related to Resident #1. A statement was requested to be completed and submitted to the local law enforcement office; however, the statement was blank, and the Administrator had not completed the statement. During an interview conducted on at 10:15 a.m. with Staff A, she stated she was coming out of the building (Building #2) when she saw Resident #1 on fire (porch of Building #3), she immediately took off his shirt and proceeded to hit the resident with the shirt to extinguish the fire and Staff A left resident on the porch to go into building # 3 and get water from the housekeeping room in the building. She then returned and poured water on the resident to assist in extinguishing the fire. Once extinguished, Staff A left Resident #1 on the porch alone, went to the main building to find the administrator (Building #1) and the resident was taken to his room in the facility. During an interview conducted on at 1:45 p.m. with Resident #2, he stated, "I was on the porch, sitting behind [Resident #1] and all of the sudden he went up in flames, I saw someone come and help."	A 025			

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A 025	Continued From page 4 A record review conducted on _____ revealed a health assessment 1823 dated _____ revealed Resident #1 had a diagnosis of _____ and _____ and _____ Resident #1 required assistance with all activities of daily living (ADLs) and assistance with self-administration of medication. A phone interview was conducted on _____ at 10:43 a.m. with the Nurse Practitioner. The Nurse Practitioner stated she was called by the Administrator who informed her that Resident #1 had caught on fire while smoking with his _____. The Nurse Practitioner stated the administrator sent her pictures of the resident's _____ and because she could not determine the extent of the _____, she informed the Administrator to take Resident #1 to her emergency room. The Nurse Practitioner stated that the Administrator informed her that Resident #1 refused to go to the emergency room. The Nurse Practitioner stated that since the resident refused to go to the emergency room, she ordered the _____ and to wash with warm water and soap and sent a consult for _____ care. The Nurse Practitioner stated she did not tell them to call 911 and that she told the Administrator that the resident needed to go to the Emergency Room. The Nurse Practitioner stated that she did not follow up with the facility regarding the resident until Tuesday, _____, and he was already in the hospital. An interview conducted on _____ at 10:53 a.m. with the _____ care agency revealed that they received a _____ care referral on _____ that Resident #1 had possibly gotten _____. When they arrived at the facility, they stated that Resident #1 was oriented and told them what _____	A 025			

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A 025	Continued From page 5 happened. They then went on to say that once they removed the _____, and saw the extent and severity of the _____, they informed the Administrator that the treatment was not something they or the facility could provide. The _____ care company made a call to a local doctor at a hospital to coordinate care and they dressed the _____ with something more appropriate. The _____ care agency stated that they could see that Resident #1 was out of breath and uncomfortable. They stated that they would not leave the facility without him going somewhere for treatment. She stated that the facility did not inform her the extent to how bad the _____ were prior to arriving at the facility. A record review conducted on _____ of _____ care progress notes dated _____ revealed that during a phone call on _____ from the Administrator that Resident #1 had an accident with smoking and _____ care informed the Administrator that they were out of town and that they recommended the resident go to the hospital for treatment. On _____, they were informed by the facility that the resident was still at the facility and needed _____ care. They informed the Administrator that they were not able to be there until _____ and the Administrator verbalized understanding. Upon the physical exam conducted on _____, it was noted that the resident's breathing was labored and _____ was noted. Resident's _____ rate was elevated, _____ pulses were diminished and mild lower extremity _____. Resident appeared _____ and in _____. Resident was unable to ambulate and required a wheelchair. Resident #1 was covered in bandages that were removed to reveal that Resident #1 had severe _____ to the _____, full _____, right flank, right arm, right axillary as well as right _____. Palpation at _____ were	A 025			

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A 025	Continued From page 6 noted to be painful. The care agency noted that they immediately told the Administrator that Resident #1 needed to go to the hospital. The notes went on to say that Resident #1 was receiving surgical care from the hospital for on over 17% of his body. During an interview conducted at 11:35 a.m. with the Administrator, he stated Resident #1 was admitted to the facility on the from another facility and Resident #1's brother stated the resident liked to smoke. The Administrator stated they would have to put Resident #1 into the wheelchair and bring him outside for fresh air. He stated that Resident #1 had an concentrator set to 3 liters. The Administrator stated that he told Resident #1 that if he was going to smoke than he needed to go to the designated area. But Resident #1 thought that he could just unhook the and start smoking. The Administrator stated he was not sure where Resident #1 got his cigarettes from. The Administrator stated that on the date of the incident Resident #1 lit himself on fire, they took his shirt off and took him to his bed. The Administrator stated that he asked Resident #1 if he wanted to go to the hospital, but he refused, so they cleaned Resident #1 up and contacted the physician. The Administrator stated he sent pictures of the to the physician and the physician sent orders to the pharmacy over the phone. During further interview with the Administrator conducted on at 11:40 a.m., he stated the facility did not contact Resident #1's family regarding the incident. He did not call 911 because Resident #1 stated he did not want to go to the hospital, and he has a right to refuse. He stated, he received the nurse practitioner's orders	A 025			

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A 025	Continued From page 7 on the phone to apply _____ and wash with soap and water every day. The Administrator stated he is not a licensed nurse, but has Assisted Living Facility CORE training and stated he could apply _____. The Administrator stated the home health agency evaluated the resident on _____ and recommended that Resident #1 be sent to the hospital. A record review conducted on _____ of hospital admission notes for Resident #1 dated _____ revealed the following: -a physical exam conducted in the emergency room. Resident #1 had _____ over _____ and right arm and scattered less severe on _____. -Resident #1 was declared a _____ alert requiring a placement of a _____ central line (_____ placed in a large _____). -Resident #1 had a _____ level of 10 on a 0-10 _____ scale, 10 meaning intense. A record review conducted on _____ of laboratory tests dated _____ for Resident #1 revealed a high _____ count of 18.2 microliters. Normal levels are considered between 4.0- 10.5 microliters (meaning the body was reacting to _____ or _____). A record review conducted on _____ of Hospital clinical notes on _____ revealed the following: -Resident #1 required the administration of _____ medication _____ 0.5 milligrams (mg) for _____ STAT (now) on _____ at 11:39 a.m. -Resident #1 required the administration of _____ medication _____ 50 micrograms for _____ STAT (now) on _____ at 11:50 a.m.)	A 025		

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A 025	Continued From page 8 -A TBSA (Total Body Surface Area) of between 17% and 20 % of _____ on his body. A record review conducted on _____ of _____ Hospital clinical notes dated on _____ revealed the resident required the administration of _____ 1000mg every 12 hours, _____ medication _____ 2mg every 4 hours, PRN (as needed), and _____ medication _____ 15 mg every 6 hours/PRN. During an interview conducted on _____ at 11:01 a.m. with Resident #1's brother, stated I'm his emergency contact and was not notified by the facility of his brother's incident when it happened. He stated the hospital called him three days after the incident. The brother stated that he called the administrator and told him he did not appreciate being called. Resident #1's brother stated that Resident #1 was a smoker and that was his _____ he smokes like a chimney, he smoked one after the other. A record review conducted on _____ of _____ hospital admission re-evaluation dated _____ report revealed Resident # 1 had positive systemic inflammatory response _____ (an inflammatory stated affecting the whole-body indicative of an _____ or non- _____ insult provoking a systemic _____ response). A record review conducted on _____ of _____ hospital clinical post _____ report dated _____ revealed a post _____ status of superficial full thickness _____ over 20% body surface area of the torso (anterior) and _____ upper extremities. A record review conducted on _____ of _____	A 025		

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A 025	Continued From page 9 hospital clinical note post _____ check report dated _____ revealed Resident #1 underwent an _____ debridement of _____ of the anterior _____ and anterior _____ application of skin _____ (surgical skin _____ of skin) to both _____ sites. An interview with the Administrator conducted on _____ at 9:20AM, revealed that the facility has seven residents (Residents #1, #3, # 5, #6, #7, #8,) in the facility that are smokers. A record review conducted on _____ of Resident #3's health assessment revealed that Resident #3's diagnosis include _____, _____, and _____. Resident also had physical _____ including needing the use of a wheelchair. Resident #3's _____ status was noted to be mild _____. On the signature page for the medical examiner, the name of the resident did not match who the assessment was for and had another resident name on it. A record review conducted on _____ of Resident # 4's physician orders, revealed that Resident #4 had orders to use 2 liters of _____ per minute via _____ as needed. There was no health assessment available for review. During an interview with Resident #4 conducted on _____ at 9:39AM, Resident #4 confirmed that she was a smoker and that she kept her smoking supplies in her room. A record review conducted on _____ revealed Resident #5's health assessment noted she was diagnosed with _____, and _____.	A 025		

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A 025	Continued From page 10 obstructions. She was a risk and required a walker for ambulation. Her health assessment also noted she required skilled nurse and (). She required supervision with ambulation, bathing, , toileting and transfer and assistance with eating and self-care. A record review conducted on revealed Resident #6's health assessment noted he was diagnosed with Stage B and major , decreased fine motor skills, poor vision, and loss of balance. Resident #6 required assistance with all activities of daily living. During an interview with Resident #6 conducted on at 10:03AM, Resident #6 confirmed that he was a smoker and that he kept his smoking supplies on his nightstand. A record review conducted on of Resident #7's health assessment, revealed that Resident #7 had diagnosis including , and . Resident #7 also had physical limitations including ambulation. During an interview with Resident #7 conducted on at 10:10AM, Resident #7 confirmed that he was a smoker and that the facility keeps his smoking supplies for him. An interview conducted on at 1:35PM with the Administrator he stated that he kept Resident #7 smoking supplies because the Resident's daughter wanted him to manage Resident #7's cigarettes. The Administrator stated that the resident smoked by himself. A record review conducted on of Resident #8's health assessment, revealed that	A 025			

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A 025	Continued From page 11 Resident #8's diagnoses included _____ type and major _____ Resident#8's _____ status stated _____ type and major _____ Their _____ nursing/treatment/ _____ service requirements included _____ management, _____ () and _____ (). During an interview with Resident #8 conducted on _____ at 9:41AM, Resident #8 confirmed that she was a smoker and that she kept her smoking supplies in a bag in her room. An attempted record review conducted on _____ revealed the facility did not have a smoking policy or Smoking Assessments. An interview conducted on _____ at 11:08 a.m. with the Administrator he stated the facility did not have smoking assessments. During an interview with the Administrator conducted on _____ at 11:50 a.m., the Administrator went on to confirm that no interventions had been put into place to prevent future occurrences. The Administrator confirmed the staff had not received any training on fire safety and the facility had not developed any policies and procedures related to fire safety and resident safe smoking practices. Class I	A 025			
A 081 SS=D	429.52(1 & 7) FS; 59A-36.011(....) FAC Training - Staff In-Service 429.52(1) (1) Each new assisted living facility employee	A 081			

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A 081	Continued From page 12 who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record. (7) Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion that covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course. 59A-36.011 (2) STAFF PRESERVICE ORIENTATION. (a) Facilities must provide a preservice orientation of at least 2 hours to all new assisted living facility employees who have not previously completed core training as detailed in subsection (1). (b) New staff must complete the preservice orientation prior to interacting with residents. (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. (d) In addition to topics that may be chosen by the facility administrator, the preservice	A 081			

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A 081	Continued From page 13 orientation must cover: 1. Resident's rights; and, 2. The facility's license type and services offered by the facility. (3) STAFF IN-SERVICE TRAINING. Facility administrators or managers shall provide or arrange for the following in-service training to facility staff: (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 _____ borne _____, may be used to meet this requirement. (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: 1. Reporting adverse incidents. 2. Facility emergency procedures including chain-of-command and staff roles relating to emergency evacuation. (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: 1. Resident rights in an assisted living facility. 2. Recognizing and reporting resident _____, neglect, and _____. The facility must use its _____ prevention policies and procedures when	A 081		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969993	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/13/2023
NAME OF PROVIDER OR SUPPLIER SUNNY VISTA ASSISTED LIVING FACILITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 8112 N 9TH ST TAMPA, FL 33604		
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A 081	Continued From page 14 offering this training. (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: 1. Resident behavior and needs. 2. Providing assistance with the activities of daily living. (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. (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. 1. All facility staff shall be provided with a copy of the facility's resident elopement response policies and procedures. 2. All facility staff shall demonstrate an understanding and competency in the implementation of the elopement response policies and procedures. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain evidence that staff received 1 hour of in-service training related to reporting adverse incidents for one (Administrator) of the two sampled staff. Findings included: During a record review of the Administrator's	A 081			

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A 081	Continued From page 15 employee record, conducted on, it was revealed that the Administrator who was hired on had no evidence of the required 1 hour of in-service training related to reporting adverse incidents. During an interview with the Administrator, conducted on at 11:35AM, the Administrator stated that he would have to ask the owner as he thought he had everything he needed. Class III	A 081			
CZ814	435.12(2)(b-d), FS Background Screening Clearinghouse 435.12 Care Provider Background Screening Clearinghouse.- (2)(b) Until such time as the are enrolled in the national retained print notification program at the Federal Bureau of Investigation, an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic submission to the Department of Law Enforcement. The	CZ814			

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CZ814	Continued From page 16 registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an individual taxpayer identification number. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain the background screening clearinghouse within 10 business days of employment changes for one (Staff A) of the two sampled staff. Findings included: Based on a record review of the facility's background screening clearing house roster, it revealed that Staff A was not listed on the roster. During an interview with Staff A, conducted on at 11:05AM, Staff A stated that she was hired in of 2022. Unclassified	CZ814			