Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953318	A. BUILDING: _____ B. WING _____	R-C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANETTE BOSTON ALF	6916 N. 30TH STREET TAMPA, FL 33610

(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 third revisit to complaint investigation (complaint number: 2023001036 and 2023002825) was conducted at Jeanette Boston Assisted Living Facility on . Deficiencies were identified at the time of survey.	{A 000}		
{A 170} SS=D	429.24(3)a Resident Refund Policy ....The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to provide a refund within 45-days of transfer for one Resident (#7) of one sampled resident that discharged from the facility to a facility that provided a higher level of care. Findings Included: A review of , , and surveys, conducted on , revealed that Resident #7 was discharged from the facility to a facility that provided a higher level of care. The facility continued to receive Resident #7's social security income funds from through . The facility did not provide Resident #7 a refund of the social security income funds that they received during that time. On , the facility continued to	{A 170}		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953318	A. BUILDING: _____ B. WING _____	R-C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEANETTE BOSTON ALF	6916 N. 30TH STREET TAMPA, FL 33610

(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 170}	Continued From page 1 owe a balance of $5621.70 to the social security agency or to Resident #7. During an attempt to review payments made to the social security agency or to Resident #7, conducted on , there was no evidence of payments provided. During an attempt to review payment arrangements for the amount owed to the social security agency or to Resident #7, there was no evidence of payment arrangements provided. During an interview with the Administrator, conducted on at 10:50am, the Administrator stated that the facility made one payment to the social security agency since . The Administrator was unable to provide evidence that a payment was made to the social security agency. The Administrator was unable to provide evidence of a payment arrangement agreed upon by the social security agency or Resident #7. Class III	{A 170}		