

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953318	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/01/2023
NAME OF PROVIDER OR SUPPLIER JEANETTE BOSTON ALF			STREET ADDRESS, CITY, STATE, ZIP CODE 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 fourth revisit to complaint investigation (complaint number: 2023001036 and 2023002825), a six-month survey, and a generator monitoring were conducted at Jeanette Boston ALF 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 (#5) of one sampled resident that discharged from the facility to a facility that provided a higher level of care. Findings Included: A review of past 2023 surveys conducted on , revealed that Resident #5 was discharged from the facility to a facility that provided a higher level of care. The facility continued to receive Resident #5's social security income funds from through . The facility did not provide Resident #5 with a	{A 170}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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{A 170}	Continued From page 1 refund of the social security income funds that they received during that time. The facility continued to owe a balance of \$5621.70 to the social security agency or to Resident #5. During an attempt to review payments made to the social security agency or to Resident #5, conducted on _____, there was no evidence of payments initially provided. The Fiscal Agent via email provided a photocopy of an uncashed check made out to the social security agency in the amount of \$300.00 for Resident #5 "Conserve Funds" with the resident's social security number noted in that section. At the top of the copy was the typed name of the agency and at the bottom was the stamped name and address of the agency. There was no signature of an agency representative of receiving the check. There was no evidence that the check was cashed by the social security agency. There was no balance due for Resident #5's social security funds noted. During an attempt to review payment arrangements for the amount owed to the social security agency or to Resident #5, there was no evidence of payment arrangement provided. During an interview with the Administrator, conducted on _____ at 01:05pm, the Administrator stated that the facility made one payment to the social security agency since _____. The Administrator was unable to provide a statement by the social security agency regarding the balance due or amount owed to the agency or to Resident #5. The Administrator was unable to provide evidence that an actual payment was received and made to the social security agency. The Administrator was unable to provide	{A 170}		

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{A 170}	Continued From page 2 evidence of a payment arrangement agreed upon by the social security agency or Resident #5. Class III	{A 170}			