

Agency for Health Care Administration

|                                                         |                                                                                                                                                                               |                                                                                         |                                                                                                                          |                          |                                                                    |
|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION     |                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966307</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>04/22/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HUDSON MANOR</b> |                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>115 EAST DAVIS BLVD<br/>TAMPA, FL 33606</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 (CHOW) survey was<br>conducted at the Hudson Manor on 4/22/24. The<br>provider had no deficiencies at the time of the<br>visit. | A 000                                                                                   |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X6) DATE