

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R
NAME OF PROVIDER OR SUPPLIER ABIGAIL (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 320 SOUTH DELAWARE TAMPA, FL 33606		
(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 Assisted Living Facility A revisit to a complaint survey, CCR# 2013000141, of _____ was conducted on _____. The Abigail, assisted living facility, had one uncorrected deficiency found at the time of the revisit.	{A 000}			
{A 152}	58A-5.023(3) FAC Physical Plant - Safe Living Environ/Other (3) OTHER REQUIREMENTS. (a) All facilities must: 1. Provide a safe living environment pursuant to Section 429.28(1)(a), F.S.; and 2. Must be maintained free of hazards; and 3. Must ensure that all existing architectural, mechanical, electrical and structural systems and appurtenances are maintained in good working order. (b) Pursuant to Section 429.27, F.S., residents shall be given the option of using their own belongings as space permits. When the facility supplies the furnishings, each resident sleeping area must have at least the following furnishings: 1. A clean, comfortable bed with a mattress no less than 36 inches wide and 72 inches long, with the top surface of the mattress a comfortable height to ensure easy access by the resident; 2. A closet or wardrobe space for hanging clothes; 3. A dresser, chest or other furniture designed for storage of personal effects; 4. A table, bedside lamp or floor lamp, and waste basket; and 5. A comfortable chair, if requested.	{A 152}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

0099

D10E12

If continuation sheet 1 of 3

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(A 152)	Continued From page 1 (c) The facility must maintain master or duplicate keys to resident _____ to be used in the event of an emergency. (d) Residents who use portable bedside commodes must be provided with privacy during use. (e) Facilities must make available linens and personal laundry services for residents who require such services. Linens provided by a facility shall be free of tears, stains and not be _____ This Statute or Rule is not met as evidenced by: Based upon observation & interview the facility did not ensure that the buildings structure was free of potential hazards related to water damaged walls & ceiling which place the residents at risk of injury & health hazards. Findings are. During the visit of _____ the facility was cited for a roof leak which resulted in interior ceiling damage and peeling wall paint above the stairway leading to the owners 2nd floor apartment and adjacent wall. The damaged wall paint and ceiling paint was peeling back and separating. At the time of this re-visit of _____ the owner stated (12 pm) that her insurance company had been out to assess the damage for the 2nd time. The roof had previously been repaired but continues to leak. She added that due to the roof structure and having several gables finding the problematic area has been difficult. She added that they are waiting for another heavy rain to assess the roof again. The insurance company	(A 152)			

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{A 152}	Continued From page 2 was back out 3 days after the agency visit on She did not have the paper work to prove the visit but would contact the insurance company and would fax the information to the office. In the mean time the administrator stated she would move 2 residents who reside in a the front of the facility to a un-occupied rear uncorrected deficiency from the visit of	{A 152}			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11966240	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
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Name of Facility ABIGAIL (THE)	Street Address, City, State, Zip Code 320 SOUTH DELAWARE TAMPA, FL 33606
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0010</u> Reg. # <u>58A-5.0181(4) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0030</u> Reg. # <u>58A-5.0182(6) FAC; 429.28</u> LSC _____	Correction Completed	ID Prefix <u>A0077</u> Reg. # <u>58A-5.019(1) FAC</u> LSC _____	Correction Completed
ID Prefix <u>A0078</u> Reg. # <u>58A-5.019(2) FAC</u> LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By State Agency	Reviewed By <i>[Signature]</i>	Date: <u>3/4/13</u>	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

2013

Administrator
Abigail (The)
320 South Delaware
Tampa, FL 33606

Dear Administrator:

This letter reports the findings of a state survey revisit that was conducted on _____, 2013, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the uncorrected deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiency identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

For Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosures: State Form 3020 & Revisit Report

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone (727) 552-2000; Fax (727) 552-1161