

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965242	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HAILES BOARDING HOME-B			STREET ADDRESS, CITY, STATE, ZIP CODE 1009 N WILLOW AVE TAMPA, FL 33607		
(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 monitoring visit was conducted on The Hailes Boarding Home-B, assisted living facility, had a deficiency found at the time of the visit.	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. (c) The facility must maintain master or duplicate keys to resident _____ to be used in the	A 152			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

110Z11

If continuation sheet 1 of 3

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965242	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HAILES BOARDING HOME-B			STREET ADDRESS, CITY, STATE, ZIP CODE 1009 N WILLOW AVE TAMPA, FL 33607		
(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 152	Continued From page 1 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 on observation and interview, the facility failed to maintain doors and floors in good working order for 2 of 4 Residents in the facility (Resident #1 and Resident #2). Findings include: 1. On at approximately 10:15 a.m. A tour of the facility was conducted. Observation of the building revealed paint on the ceiling above the hallway entry door peeling. Further observations revealed a large hole in Resident #1's door. Resident #1's door knob was observed hanging in the middle of the hole. The door was observe to not be able to lock, due to the door knob not being properly affixed to the door. 2. On at 10:23 a.m. Resident #1 was interviewed. Resident #1 stated his door has been broken for years. He confirmed that he is unable to lock and unlock his door. On the administrator was interviewed. She stated, that she goes down to Resident #1 every day and she never noticed the door was broken.	A 152			

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965242	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HAILES BOARDING HOME-B			STREET ADDRESS, CITY, STATE, ZIP CODE 1009 N WILLOW AVE TAMPA, FL 33607		
(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 152	Continued From page 2 On _____ Staff A was interviewed. Staff A confirmed the doors in the facility have been broken for, "a long time." Staff A stated the administrator and other staff members are aware of the conditions of the doors in the facility. Class III	A 152			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Hailes Boarding Home-B
1009 N Willow Ave
Tampa, FL 33607

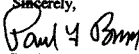
Dear Administrator:

This letter reports the findings of a monitoring visit 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 deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these 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

Enclosure: State Form 3020

