STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966240	R
NAME OF PROVIDER OR SUPPLIER **ABIGAIL (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **320 SOUTH DELAWARE** **TAMPA, FL 33606**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Assisted Living Facility

A revisit to a biennial state licensure survey was conducted at The Abigail on . The Abigail, Assisted Living Facility, had one uncorrected deficiency and one new deficiency at the time of the visit.

(Lic. # 10498)

0162 Records - Resident

Based on record review and interview, the file for one of four residents sampled (#4) did not contain all required records available for agency inspection.

Findings included:

A review of the record for Resident #4 during the revisit found a health assessment indicating that this individual required "administration of medications." This was also the same level indicated in the resident's and health evaluations. Upon inquiry at 1:15pm on , the designee stated that "the resident receives medication administration from a home health nurse for all meds." Further review of the resident's file, including the home health record, found no documented evidence that the resident was receiving this service--both from an official physician's order as well as daily entries on a medication administration record (MAR). Further interview with the designee provided no explanation where said documentation was located.

Class III

0167 Resident Contracts

Based on record review and interview, the contract for four of four residents sampled (#1-4) was still missing required provisions.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966240	R
NAME OF PROVIDER OR SUPPLIER **ABIGAIL (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **320 SOUTH DELAWARE** **TAMPA, FL 33606**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

Findings included:

A review of resident files during the revisit to the survey revealed that the residency agreement did not contain the following verbiage:
a) there was no clause indicating that the facility would provide the resident/responsible party with at least 30 days written notice of any rate increase and
b) although there was an addendum stating that the resident/responsible party was required to provide the facility with at least 45 days written notice of discharge, this was NOT the case; further review of the record found no provision officially addressing this error.

Interview with the administrative designee at 12:45pm on provided no explanation why this deficiency had not been corrected.

(Please Note: This is an uncorrected deficiency from the survey).

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11966240 Y1	A. Building B. Wing Y2	Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ABIGAIL (THE)	320 SOUTH DELAWARE TAMPA, FL 33606

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0008	Correction	ID Prefix A0052	Correction	ID Prefix A0078	Correction
Reg. # 429.26(4-6) FS; 58A-5.0181(2) FAC	Completed	Reg. # 58A-5.0185 (3)	Completed	Reg. # 58A-5.019(2) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0080	Correction	ID Prefix A0083	Correction	ID Prefix A0084	Correction
Reg. # 429.52(1-2) FS; 58A-5.0191(1) FAC	Completed	Reg. # 58A-5.0191(4) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0161	Correction	ID Prefix AZ814	Correction	ID Prefix	Correction
Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed	Reg. # 435.12(2)(b-d), FS	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	PCS	6/23/16		
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/5/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT (. . . . .) EVENT ID: KRNN12

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2016, by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies identified during the revisit.

All deficiencies shall be corrected no later than , 2016.

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, of this office at (727) 552-2000.

Sincerely,

Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosures: State (5000-3547) Form & Revisit Report

BBT7

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