STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966307	**01/11/2017**
NAME OF PROVIDER OR SUPPLIER **HUDSON MANOR**	STREET ADDRESS, CITY, STATE, ZIP CODE **115 EAST DAVIS BLVD TAMPA, FL 33606**	

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

0000 - Initial Comments

Assisted Living Facility

On 11, 2017, a biennial relicensure survey was conducted at Hudson Manor. A deficiency was identified at the time of the visit.

(license #10528)

0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC

Based on record review and interview the facility failed to maintain and submit a required state report for 1 of 3 resident records reviewed (#15) resulting in a condition that required the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident.

Findings included:

On , 2017 a record review was conducted for resident #15. In review of the record an in house report was initiated on due to a resulting in resident #15 being admitted in the hospital with a diagnosis of a head , eventually being transferred to a rehabilitation center for more acute care.

On , 2017 at 2:30 pm an interview was conducted with the Administrator. They stated they should have initiated an adverse incident report for resident #15 but due to other circumstances.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

, 2017

Administrator
Hudson Manor
115 East Davis Blvd
Tampa, FL 33606

Dear Administrator:

This letter reports the findings of a biennial state licensure survey that was conducted on , 2017, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiency. Submit summary and documents to the Field Office no later than , 2017.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiency identified on your survey, which may include a desk review or onsite revisit.

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.

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Thank you for the assistance provided to the surveyor(s). Should you have any questions please call **Teresa Ryan**, RNC, at 727-552-2000.

Sincerely,

Teresa Ryan RNC

Patricia Reid Ullman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90