

Agency for Health Care Administration

|                                                                   |                                                                                                                                                         |                                                                                |                                                                                                                          |  |                                                                    |
|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11953622</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>04/20/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKDALE AT BAY PINES</b> |                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9797 BAY PINES BLVD</b><br><b>SAINT PETERSBURG, FL 33708</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 follow-up survey was conducted on 04/20/2020<br>at The Pointe. Previous cited deficiencies were<br>corrected via desk review. | {A 000}                                                                        |                                                                                                                          |  |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X6) DATE