Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968024	A. BUILDING: _____ B. WING _____	R 04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE SENIOR LIVING AT ST PETERSBURG	3479 54TH AVE N SAINT PETERSBURG, FL 33714

(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 A second revisit to the complaint (complaint numbers 2021000827 and 2021001502) survey of 1/26/2021 in conjunction with a revisit to the complaint (complaint numbers 2021003596 and 2021002718) survey of 3/10/2021 and in conjunction with a complaint (complaint numbers 2021003698, 2021004270, 2021004864 & 2021005492) with a COVID-19 focused infection control and generator monitoring survey was conducted at Noble Senior Living At St. Petersburg on 04/21/2021. There was no deficient practice identified at the time of the survey.	{A 000}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE