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
	AL11969717	A. BUILDING: _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER

SEACOAST AT UPTOWN OAKS

STREET ADDRESS, CITY, STATE, ZIP CODE

12250 N 22ND STREET
TAMPA, FL 33612

(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 complaint investigation (complaint number: 2024014472) and a generator monitoring were conducted at Seacoast at Uptown Oaks on 10/29/2024. The facility had no deficiencies at the time of the survey.	A 000		