

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>06/26/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>THE POINTE</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 06/26/25 for<br>Colliers at St. Pete (The Pointe). Previously cited<br>deficiencies were corrected via desk review. | {A 000}                                                                                                   |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X8) DATE