

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11922290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/09/2012
NAME OF PROVIDER OR SUPPLIER CHATEAU PALMS INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1679 TAMPA ROAD PALM HARBOR, FL 34683		
(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)
A 000	Initial Comments Assisted Living Facility An initial limited mental health (LMH) state licensure survey was completed on 07/09/12 in conjunction with a change of ownership (CHOW) with limited nursing services (LNS), see (Aspen Event EUV511). Chateau Palms Inc. had no deficiencies found relative to the initial LMH survey. Deficiencies were cited relative to the change of ownership (CHOW) with limited nursing services (LNS), see (Aspen Event EUV511).		A 000	

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0599

8JH811

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

July 13, 2012

Administrator
Chateau Palms, Inc
1679 Tampa Road
Palm Harbor, FL 34683

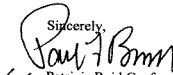
Dear Administrator:

This letter reports the findings of a change of ownership (CHOW) state licensure survey and an initial limited mental (LMH) state licensure survey that were conducted on July 9, 2012, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit relative to the CHOW survey. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosures: State Forms 3020

