

Agency for Health Care Administration

|                                                                               |                                                                                                                                                                                                                                            |                                                                                |                                                                                              |                                                                                                                          |                                                        |
|-------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                           |                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967471</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                             |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/05/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HYDE PARK ASSISTED LIVING FACILITY</b> |                                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3011 WEST DE LEON STREET<br/>TAMPA, FL 33609</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                                                                         | <p>Initial Comments</p> <p>Assisted Living Facility</p> <p>An extended congregate care (ECC) monitoring visit was conducted on 10/05/12.</p> <p>Hyde Park Assisted Living facility had no deficiencies found at the time of the visit.</p> |                                                                                | A 000                                                                                        |                                                                                                                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

ITSH11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

October 11, 2012

Administrator  
Hyde Park Assisted Living Facility  
3011 West De Leon Street  
Tampa, FL 33609

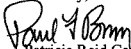
Dear Administrator:

This letter reports findings of an extended congregate care (ECC) monitoring visit that was conducted on October 5, 2012, by representative of this office. Attached is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the 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

Enclosure: State Form 3020

