

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 01/23/2013
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)	(X5) COMPLETE DATE
A 000	Initial Comments Assisted Living Facility A limited nursing services (LNS) monitoring visit was completed on 01/23/13 in conjunction with a complaint survey, CCR# 2012013738, see Aspen Event JOTM11). The Chateau Palms Inc., assisted living facility, had no deficiencies found relative to the LNS monitoring visit. Deficiencies were cited relative to the complaint survey, CCR# 2012013738, see Aspen Event JOTM11).	A 000		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

Y10V11

If continuation sheet 1 of 1

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

January 30, 2013

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

Dear Administrator:

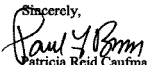
Re: CCR# 2012013738 & LNS Monitoring Visit

This letter reports the findings of a complaint survey and a limited nursing services (LNS) monitoring visit that was conducted on January 23, 2013, 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 complaint 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

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