

6/18/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967471	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 6/4/2013
Name of Facility HYDE PARK ASSISTED LIVING FACILITY		Street Address, City, State, Zip Code 3011 WEST DE LEON STREET TAMPA, FL 33609

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0030</u> Reg. # <u>58A-5.0182(6) FAC; 429.28</u> LSC _____	Correction Completed <u>06/04/2013</u>	ID Prefix <u>A0055</u> Reg. # <u>58A-5.0185(6) FAC</u> LSC _____	Correction Completed <u>06/04/2013</u>	ID Prefix <u>A0077</u> Reg. # <u>58A-5.019(1) FAC</u> LSC _____	Correction Completed <u>06/04/2013</u>
ID Prefix <u>A0079</u> Reg. # <u>58A-5.019(4) FAC</u> LSC _____	Correction Completed <u>06/04/2013</u>	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed <u>06/04/2013</u>	ID Prefix <u>A0152</u> Reg. # <u>58A-5.023(3) FAC</u> LSC _____	Correction Completed <u>06/04/2013</u>
ID Prefix <u>A0160</u> Reg. # <u>58A-5.024(1) FAC</u> LSC _____	Correction Completed <u>06/04/2013</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency _____	Reviewed By <u>Paul V. Barr</u> Date: <u>6/18/13</u>	Signature of Surveyor: _____ Date: _____
Reviewed By _____ CMS RO _____	Reviewed By _____ Date: _____	Signature of Surveyor: _____ Date: _____

Followup to Survey Completed on:

3/12/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 18, 2013

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

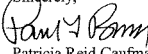
Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on June 4, 2013, by a representative of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the revisit.

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: Revisit Report

