

Agency for Health Care Administration

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|------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967604</b>            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/13/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOOD HOPE OF PINELLAS</b> |                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7575 65TH WAY<br/>PINELLAS PARK, FL 33781</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>Two complaint surveys, CCR# 2013005748 &amp;<br/>CCR# 2103004492, were conducted on 6/13/13.</p> <p>The Good Hope of Pinellas, assisted living facility,<br/>had no deficiencies at the time of the surveys.</p> | A 000                                                                                     |                                                                                                                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6906

OSXD11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

June 21, 2013

Administrator  
Good Hope of Pinellas  
7575 65th Way  
Pinellas Park, FL 33781

Dear Administrator:

This letter reports the findings of a state licensure survey revisit and two complaint surveys conducted on June 13, 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, and the State (3020) Form, which indicates no deficiencies were identified at the time of the complaint surveys.

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,

Patricia Reid Cauffman  
Field Office Manager

For

PRC/kpr

Enclosures: Revisit Report & State Form 3020

