

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 55245	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/29/2021
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NAME OF PROVIDER OR SUPPLIER SOUTH HERITAGE HEALTH & REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 718 LAKEVIEW AVE S SAINT PETERSBURG, FL 33705
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(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
{N 000}	<p>INITIAL COMMENTS</p> <p>An unannounced Revisist survey was conducted on 07/29/2021 at South Heritage Health and Rehabilitation Center, St. Petersburg. No deficiencies were identified at the time of the survey, and previously cited deficiencies were found corrected.</p>	{N 000}		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

Electronically Signed

08/12/21

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105117	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 07/29/2021
NAME OF PROVIDER OR SUPPLIER SOUTH HERITAGE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 718 LAKEVIEW AVE S SAINT PETERSBURG, FL 33705		
(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) COMPLETION DATE	
{F 000}	INITIAL COMMENTS An unannounced Revisit survey was conducted on 07/29/2021 at South Heritage Health and Rehabilitation Center, St. Petersburg. The Facility was in compliance with 42 CFR 483, Requirements for Long Term Care Facilities; previously cited deficiencies were found corrected.	{F 000}			

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

TITLE

(X6) DATE

Electronically Signed

08/12/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.