

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>AL11968253</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/29/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GENTLE CARE ASSISTED LIVING 3</b> |                                                                                                                                                                                                                                                     |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>27 ROLLING SANDS DR<br/>PALM COAST, FL 32164</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>CCR #2012005892</p> <p>An unannounced complaint survey was conducted at Gentle Care Assisted Living 3 in Palm Coast, Florida on June 29, 2012. Licensure deficiencies were not identified as a result of the survey.</p> | A 000                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

29ZZ11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

July 2, 2012

Administrator  
Gentle Care Assisted Living 3  
27 Rolling Sands Dr  
Palm Coast, FL 32164

**Re: CCR #2012005892**

Dear Administrator:

This letter reports the findings of a complaint survey completed on June 29, 2012 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, State (3020) Form, indicating no deficiencies were identified during this 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 contact this office at (904) 798-4201.

Sincerely,

Keisha Woods, MPH  
Health Facility Evaluator Supervisor  
Division of Health Quality Assurance

NH/KW/sm  
Enclosure

