

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967417	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/6/2012
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Name of Facility BLAKE AT GULF BREEZE (THE)	Street Address, City, State, Zip Code 4410 GULF BREEZE PARKWAY GULF BREEZE, FL 32563
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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>A0163</u> Reg. # <u>429.49 FS</u> LSC _____	Correction Completed 07/06/2012	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
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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 _____ CMS RO _____	Reviewed By <u>[Signature]</u> Reviewed By _____	Date: <u>7/10/12</u> Date: _____ Signature of Surveyor: <u>[Signature]</u> Signature of Surveyor: _____	Date: <u>7/10/12</u> Date: _____
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Followup to Survey Completed on: 5/4/2012	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967417	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/06/2012
NAME OF PROVIDER OR SUPPLIER BLAKE AT GULF BREEZE (THE)			STREET ADDRESS, CITY, STATE, ZIP CODE 4410 GULF BREEZE PARKWAY GULF BREEZE, FL. 32563		
(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 A follow-up survey for CCR# 2012004709 complaint investigation was conducted beginning on 7/5/12 through 7/6/12. Blake at Gulf Breeze (the), Assisted Living Facility, had no deficiencies found at the time of the survey.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0099

DTYH12

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

July 9, 2012

Administrator
Blake At Gulf Breeze (the)
4410 Gulf Breeze Parkway
Gulf Breeze, FL 32563

RE: revisiit to CCR 2012004709

Dear Administrator:

This letter reports the findings of a complaint investigation revisit survey conducted on July 6, 2012 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. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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 me at 850-412-4540.

Sincerely,


for Donah Heiberg, MSW
Field Office Manager

Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



Tallahassee Field Office
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