



RICK SCOTT  
GOVERNOR

**Better Health Care for all Floridians**

ELIZABETH DUDEK  
SECRETARY

July 17, 2012

Administrator  
Highland Terrace  
700 Medical Court East  
Inverness, FL 34452

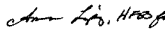
Dear Administrator:

This letter reports the findings of a monitoring visit that was conducted on June 29, 2012 by a representative of this office. Enclosed is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the 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 call this office at (386) 462-6201.

Sincerely,

  
Kriste J. Mennella  
Field Office Manager

KJM/amw

Enclosure



Agency for Health Care Administration

|                                                             |                                                                                                                                                                                    |                                                                                |                                                                                                |                                                                                                                          |                                                        |
|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964467</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>HIGHLAND TERRACE</b> |                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>700 MEDICAL COURT EAST<br/>INVERNESS, FL 34452</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                                                       | Initial Comments<br><br>A monitoring for possible opening of the second floor was conducted on 06/29/2012. No life threatening concerns were identified 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

0009

CRRM11

If continuation sheet 1 of 1