

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/01/2012
NAME OF PROVIDER OR SUPPLIER AVALON ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 2580 FIRST STREET FORT MYERS, FL 33901		
(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 This is the follow-up to Complaint survey CCR# 2012006243 completed on 8/1/12 at Avalon, an Assisted Living Facility. All previous citations have been substantially improved or corrected. No deficiencies were cited relevant to the survey during this visit.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0899

Q2PN12

If continuation sheet 1 of 1

8/6/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11968083(Y2) Multiple Construction
A. Building
B. Wing(Y3) Date of Revisit
8/1/2012Name of Facility
AVALON ASSISTED LIVINGStreet Address, City, State, Zip Code
2580 FIRST STREET
FORT MYERS, FL 33901

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>A0025</u> Reg. # <u>58A-5.0182(1) FAC</u> LSC _____	Correction Completed 08/01/2012	ID Prefix <u>A0052</u> Reg. # <u>58A-5.0185(3) FAC</u> LSC _____	Correction Completed 08/01/2012	ID Prefix <u>A0054</u> Reg. # <u>58A-5.0185(5) FAC</u> LSC _____	Correction Completed 08/01/2012
ID Prefix <u>A0084</u> Reg. # <u>58A-5.0191(5) FAC</u> LSC _____	Correction Completed 08/01/2012	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
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 _____

Reviewed By _____

Date: _____

Signature of Surveyor: _____

Date: _____

State Agency _____

State Agency _____

Date: _____

Signature of Surveyor: _____

Date: _____

Reviewed By _____

Reviewed By _____

Date: _____

Signature of Surveyor: _____

Date: _____

CMS RO _____

Followup to Survey Completed on:

6/13/2012

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 6, 2012

Administrator
Avalon Assisted Living
2580 First Street
Fort Myers, FL 33901

Dear Administrator:

This letter reports the findings of a Complaint survey revisit conducted on August 1, 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 this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

bw
Enclosure

