

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11964714	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/9/2012
---	--	----------------------------------

Name of Facility DOREEN'S ASSISTED LIVING HOME	Street Address, City, State, Zip Code 3045 S. SEACREST BLVD. BOYNTON BEACH, FL 33435
---	--

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>A0030</u> Reg. # <u>58A-5.0182(6) FAC; 429.28</u> LSC _____	Correction Completed	ID Prefix <u>A0056</u> Reg. # <u>58A-5.0185(7) FAC</u> LSC _____	Correction Completed	ID Prefix <u>A0084</u> Reg. # <u>58A-5.0191(5) FAC</u> 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: <u>8-14-12</u>	Signature of Surveyor: <u>Morisa Thurman Smith (reg)</u>	Date: <u>8-14-12</u>
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____			
CMS RO _____				

Followup to Survey Completed on:

12/14

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

YES NO



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Doreen's Assisted Living Home
3045 S. Seacrest Boulevard
Boynton Beach, FL 33435

Dear Administrator:

This letter reports the findings of a second revisit to complaint survey CCR# 2011010877 conducted on 2012 by a representative of this office. Attached is the provider's copy of the State Form Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the revisit.

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 this agency's representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

A.C. Boyle, HCC Supervisor
for Arlene Mayo-Davis
Field Office Manager

AMD/hl
Enclosure

