

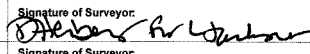
8/20/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967971	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/15/2012
Name of Facility FLORIDA ASSISTANT LIVING ORGANIZATION LAKE SHORE		Street Address, City, State, Zip Code 585 LAKE SHORE DRIVE MADISON, FL 32340

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>A0008</u> Reg. # <u>58A-5.0181(2) FAC</u> LSC _____	Correction Completed <u>08/15/2012</u>	ID Prefix <u>A0011</u> Reg. # <u>58A-5.0181(5) FAC</u> LSC _____	Correction Completed <u>08/15/2012</u>	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed <u>08/15/2012</u>
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	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: 	Date: <u>8/20/12</u>
State Agency _____	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

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967971	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/15/2012
NAME OF PROVIDER OR SUPPLIER FLORIDA ASSISTANT LIVING ORGANIZATION			STREET ADDRESS, CITY, STATE, ZIP CODE 585 LAKE SHORE DRIVE MADISON, FL 32340		
(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 On 8/15/2012 an unannounced revisit survey to the biennial survey on 6/13/12 was conducted at Florida Assistant Living Organization facility. At the time of the revisit all deficiencies were cleared.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0099

7T3B12

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 20, 2012

Administrator
Florida Assistant Living Organization Lake Shore
585 Lake Shore Drive
Madison, FL 32340

Dear Administrator:

This letter reports the findings of a state licensure revisit survey conducted on August 15, 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,

Denah Heiberg, MSW
Field Office Manager

Enclosure

