

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967351	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/15/2012
Name of Facility TORIA'S ASSISTED LIVING FACILITY I		Street Address, City, State, Zip Code 2073 BALFOUR CIRCLE TAMPA, FL 33619

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 08/15/2012	ID Prefix <u>A0025</u> Reg. # <u>58A-5.0182(1) FAC</u> LSC _____	Correction Completed 08/15/2012	ID Prefix <u>A0055</u> Reg. # <u>58A-5.0185(6) FAC</u> LSC _____	Correction Completed 08/15/2012
ID Prefix <u>A0078</u> Reg. # <u>58A-5.019(2) FAC</u> LSC _____	Correction Completed 08/15/2012	ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC _____	Correction Completed 08/15/2012	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed 08/15/2012
ID Prefix <u>A0162</u> Reg. # <u>58A-5.024(3) FAC</u> LSC _____	Correction Completed 08/15/2012	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

Reviewed By  State Agency ☒ Reviewed By _____ CMS RO	Date: <u>8/22/12</u> Date: _____	Signature of Surveyor: _____ Signature of Surveyor: _____	Date: _____ Date: _____
Followup to Survey Completed on: 4/27/2012		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 22, 2012

Administrator
Toria's Assisted Living Facility I
2073 Balfour Circle
Tampa, FL 33619

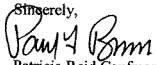
Dear Administrator:

This letter reports the findings of a state licensure survey revisit 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.

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 **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

for. Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: Revisit Report

