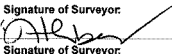


State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11910470	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/22/2012
Name of Facility CARPENTER'S CREEK COMMUNITY		Street Address, City, State, Zip Code 5918 NORTH DAVIS HIGHWAY PENSACOLA, FL 32503

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>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC <u></u>	Correction Completed 08/22/2012	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed
ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed
ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed
ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed
ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed
ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed
ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed	ID Prefix <u></u> Reg. # <u></u> LSC <u></u>	Correction Completed

Reviewed By <u></u> State Agency <u></u> Reviewed By <u></u> CMS RO <u></u>	Reviewed By <u></u> Reviewed By <u></u>	Date: <u></u> Date: <u></u>	Signature of Surveyor: <u></u> Signature of Surveyor: <u></u>	Date: <u>8/20/12</u> Date: <u></u>
Followup to Survey Completed on: 8/8/2012		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: AL11910470	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/22/2012
NAME OF PROVIDER OR SUPPLIER CARPENTER'S CREEK COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 5918 NORTH DAVIS HIGHWAY PENSACOLA, FL 32503		
(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 A revisit (desk review) was completed. Based on the plan of correction and supplemental materials provided, the previously identified citation was found corrected.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6000

4LPH12

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 22, 2012

Administrator
Carpenter's Creek Community
5918 North Davis Highway
Pensacola, FL 32503

Dear Administrator:

This letter reports findings of a state licensure revisit (desk review) survey that was conducted on August 22, 2012 by representative(s) of this office. Attached 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.

Should you have any questions please call me at 850-412-4540.

Sincerely,

Donah Heiberg
Field Office Manager

Dh/dh
Enclosure

65FO

