

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967442	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/30/2012
Name of Facility GOLDEN ABBEY ORMOND BEACH		Street Address, City, State, Zip Code 1410 HAND AVENUE ORMOND BEACH, FL 32174

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>A0007</u> Reg. # <u>58A-5.0181(1) FAC</u> LSC _____	Correction Completed 10/30/2012	ID Prefix <u>A0055</u> Reg. # <u>58A-5.0185(6) FAC</u> LSC _____	Correction Completed 10/30/2012	ID Prefix <u>A0057</u> Reg. # <u>58A-5.0185(8) FAC</u> LSC _____	Correction Completed 10/30/2012
ID Prefix <u>A0078</u> Reg. # <u>58A-5.019(2) FAC</u> LSC _____	Correction Completed 10/30/2012	ID Prefix <u>A0092</u> Reg. # <u>58A-5.020(1) FAC</u> LSC _____	Correction Completed 10/30/2012	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed 10/30/2012
ID Prefix <u>A0162</u> Reg. # <u>58A-5.024(3) FAC</u> LSC _____	Correction Completed 10/30/2012	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 <u>[Signature]</u> State Agency	Reviewed By <u>[Signature]</u> CMS RO	Date: <u>11/7/2012</u>	Signature of Surveyor: <u>[Signature]</u>	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 7/31/2012	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

November 7, 2012

Administrator
Golden Abbey Ormond Beach
1410 Hand Avenue
Ormond Beach, FL 32174

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on October 30, 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 this office at (904) 798-4201.

Sincerely,

Keisha Woods, MPH
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

KW/sm
Enclosure

