

12/19/2012

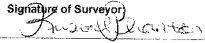
State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967137	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/6/2012
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Name of Facility A-1 ASSISTED LIVING FACILITY LLC	Street Address, City, State, Zip Code 9410 SW 52 TERRACE MIAMI, FL 33165
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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>A0025</u> Reg. # <u>58A-5.0182(1) FAC</u> LSC _____	Correction Completed 12/06/2012	ID Prefix <u>A0054</u> Reg. # <u>58A-5.0185(5) FAC</u> LSC _____	Correction Completed 12/06/2012	ID Prefix <u>A0078</u> Reg. # <u>58A-5.019(2) FAC</u> LSC _____	Correction Completed 12/06/2012
ID Prefix <u>A0162</u> Reg. # <u>58A-5.024(3) FAC</u> LSC _____	Correction Completed 12/06/2012	ID Prefix <u>AZ821</u> Reg. # <u>59A-35.110, FS</u> LSC _____	Correction Completed 12/06/2012	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	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 _____	Date: _____	Signature of Surveyor: 	Date: <u>12/19/2012</u>
Reviewed By _____ CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 8/7/2012	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

January 2, 2013

Administrator
A-1 Assisted Living Facility Llc
9410 Sw 52 Terrace
Miami, FL 33165

Dear Administrator:

This letter reports the findings of a state licensure survey 2nd revisit conducted on December 6, 2012 by representative(s) 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(s). Should you have any questions please call Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

E. O. Mayo-Davis
Arlene Mayo-Davis *FM*
Field Office Manager

AMD:sy
Enclosure

J5XD

