

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967973	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 1/11/2013
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Name of Facility MEADOWLANDS SENIOR LIVING	Street Address, City, State, Zip Code 3533 NE STATE RD #6 MADISON, FL 32340
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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 AL241 Reg. # 58A-5.029(2) FAC LSC	Correction Completed 01/11/2013	ID Prefix AZ815 Reg. # 408.809, 435.02(2), 435.06 LSC	Correction Completed 01/11/2013	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
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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: <i>PmGhturanc</i>	Date: 1/16/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
11/16/2012

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: AL11967973	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/11/2013
NAME OF PROVIDER OR SUPPLIER MEADOWLANDS SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3533 NE STATE RD #6 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 1/11/2013 an unannounced Licensure re-visit was conducted at Meadowlands Senior Living. There were no deficiencies found at the time of the revisit.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6890

E60D12

If continuation sheet 1 of 1

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

January 16, 2013

Administrator
Meadowlands Senior Living
3533 Ne State Rd #6
Madison, FL 32340

Dear Administrator:

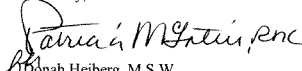
This letter reports the findings of a state licensure survey revisit conducted on January 11, 2013 by a representative of this office.

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,


Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure

J5XD

