

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11964272

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
1/14/2013

Name of Facility

DAYSRING RETIREMENT CENTER, INC

Street Address, City, State, Zip Code

2906 COCOA AVENUE
PANAMA CITY, FL 32405

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>A0054</u> Reg. # <u>58A-5.0185(5) FAC</u> LSC	Correction Completed 01/14/2013	ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC	Correction Completed 01/14/2013	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC	Correction Completed 01/14/2013
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By
State Agency

Reviewed By

Date:

Signature of Surveyor:

Date:

Reviewed By
CMS RO

Reviewed By

Date:

Signature of Surveyor:

Date:

Followup to Survey Completed on:

11/21/2012

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: AL11964272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 01/14/2013
NAME OF PROVIDER OR SUPPLIER DAYSRING RETIREMENT CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2906 COCOA AVENUE PANAMA CITY, FL 32405		
(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 01/14/2013 an unannounced Licensure-revisit survey was conducted at Dayspring Retirement Center. At the time of the revisit, no deficiencies were found.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

8899

LM0012

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

January 16, 2013

Administrator
Dayspring Retirement Center, Inc
2906 Cocoa Avenue
Panama City, FL 32405

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on January 14, 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

