State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11911081	A. Building B. Wing	2/21/2011

Name of Facility	Street Address, City, State, Zip Code
TWIN CITIES PAVILION	1053 JOHN SIMS PARKWAY NICEVILLE, FL 32578

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 A0025 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A0201 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A0222 Reg. # LSC	Correction Completed 02/21/2011
ID Prefix A0223 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A0224 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A0425 Reg. # LSC	Correction Completed 02/21/2011
ID Prefix A0510 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A0511 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A0512 Reg. # LSC	Correction Completed 02/21/2011
ID Prefix A0513 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A0806 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A0808 Reg. # LSC	Correction Completed 02/21/2011
ID Prefix A0812 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A1001 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix A1104 Reg. # 381.0035 (1), F.S. LSC	Correction Completed 02/21/2011

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor: Patricia M Tullis RN	Date: 2/28/11
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A1108 Reg. # LSC	Correction Completed 02/21/2011				

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency			Patricia M Gatlin RN	2/28/11
Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
CMS RO				

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/28/2010				

AH Form Approved
2/24/2011

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11911081	A. Building B. Wing	2/21/2011

Name of Facility	Street Address, City, State, Zip Code
TWIN CITIES PAVILION	1053 JOHN SIMS PARKWAY NICEVILLE, FL 32578

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 E0603 Reg. # LSC	Correction Completed 02/21/2011	ID Prefix E0713 Reg. # LSC	Correction Completed 02/21/2011	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: Patricia McIntire RN	Date: 2/28/11
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/28/2010				

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911081	A. BUILDING _____ B. WING _____	R 02/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES PAVILION	1053 JOHN SIMS PARKWAY NICEVILLE, FL 32578

(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
{E 000}	INITIAL COMMENTS A follow up survey to 12/28/10 was conducted on 2/21/11. Citations E0603 and E0713 were cleared and the facility was found to be in compliance with F.S. 429.01-429.54, Part I 429.07(3)(b) and 58A-5.030 F.A.C. at the time of this survey.	{E 000}		

AHCA Form 3020-0001

TITLE (X6) DATE

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

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911081	A. BUILDING _____ B. WING _____	R 02/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES PAVILION	1053 JOHN SIMS PARKWAY NICEVILLE, FL 32578

(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 follow up survey to 12/28/10 was conducted on 2/21/11. Citations A0025, A0201, A0222, A0223, A0224, A0425, A0510, A0511, A0512, A0513, A0806, A0808, A0812, A1001, A1104, A1108 were cleared and the facility was found to be in compliance with F.S. 429.01-429.54, Part I and 58A-5 F.A.C. at the time of this survey.	{A 000}		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
INTERIM SECRETARY

February 24, 2011

Administrator
Twin Cities Pavilion
1053 John Sims Parkway
Niceville, FL 32578

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on February 21, 2011 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,

Barbara Alford, R.N., B.S.N.
Tallahassee Field Office Manager

Enclosure

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