

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11965162

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
1/17/2013

Name of Facility

VILLAS AT GULF BREEZE, INC

Street Address, City, State, Zip Code

101 MCABEE COURT
GULF BREEZE, FL 32561

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
	Correction Completed 01/17/2013		Correction Completed 01/17/2013		Correction Completed
ID Prefix A0030		ID Prefix A0165		ID Prefix	
Reg. # 58A-5.0182(6) FAC; 429.28		Reg. # 429.23 FS; 58A-5.0241 FAC		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By
State Agency
Reviewed By
CMS RO

Reviewed By
[Signature]
Reviewed By

Date:
3/19/12
Date:

Signature of Surveyor:
[Signature]
Signature of Surveyor:

Date:
3/19/12
Date:

Followup to Survey Completed on:

10/31/2012

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: AL11965162	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/14/2013
NAME OF PROVIDER OR SUPPLIER VILLAS AT GULF BREEZE, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 101 MCABEE COURT GULF BREEZE, FL 32561		
(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 3/13/2013 - 3/14/2013, a follow up survey was conducted at the Villas Gulf Breeze. In conjunction with the revisit, a complaint survey (CCR#2013001141 and 2013002397) was also conducted. The Assisted Living Facility had no deficiencies found in conjunction with the revisit.	{A 000}		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0399

T7SC12

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

March 19, 2013

Administrator
Villas At Gulf Breeze, Inc
101 McAbee Court
Gulf Breeze, FL 32561

RE: CCR #2013001141 and 2013002397

Dear Administrator:

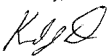
This letter reports the findings of a complaint survey and a revisit survey conducted on March 14, 2013 by representative(s) of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), which references the new deficiencies identified during the survey.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than March 19, 2013.**

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 850-412-4540.

Sincerely,


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

DH/kb
Enclosure

BBT7

