

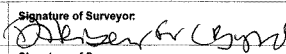
4/19/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967639	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/10/2013
Name of Facility HILL VIEW ASSISTED LIVING	Street Address, City, State, Zip Code 3854 HIGHWAY 2 GRACEVILLE, FL 32440	

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 A0052 Reg. # 58A-5.0185(3) FAC LSC	Correction Completed 04/10/2013	ID Prefix A0084 Reg. # 58A-5.0191(5) FAC LSC	Correction Completed 04/10/2013	ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed 04/10/2013
ID Prefix A0162 Reg. # 58A-5.024(3) FAC LSC	Correction Completed 04/10/2013	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 _____ CMS RO	Date: _____	Signature of Surveyor: 	Date: 4/19/13
Followup to Survey Completed on: 2/5/2013	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: AL11967639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/10/2013
NAME OF PROVIDER OR SUPPLIER HILL VIEW ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3854 HIGHWAY 2 GRACEVILLE, FL 32440		
(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 April 10, 2013 an unannounced revisit survey was conducted at Hill View Assisted Living Facility. There were no deficiencies found at the time of the visit.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

E5EO12

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

April 19, 2013

Administrator
Hill View Assisted Living
3854 Highway 2
Graceville, FL 32440

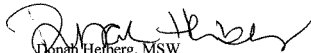
Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on April 10, 2013 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. **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(s). Should you have any questions please call me at 850-412-4540.

Sincerely,


Donah Herberg, MSW
Field Office Manager

DH/dh
Enclosure

J5XD

