



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

May 6, 2013

Administrator
Parkside Assisted Living
329 Church Street
Starke, FL 32091

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on April 22, 2013 by a representative of this office. Enclosed 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 this office at (386) 462-6201.

Sincerely,



Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure

J5XD

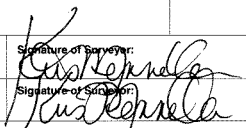
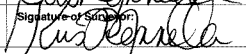


5/6/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11968001	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/22/2013
Name of Facility PARKSIDE ASSISTED LIVING		Street Address, City, State, Zip Code 329 CHURCH STREET STARKE, FL 32091

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>A0052</u> Reg. # <u>58A-5.0185(3) FAC</u> LSC _____	Correction Completed 04/22/2013	ID Prefix <u>A0054</u> Reg. # <u>58A-5.0185(5) FAC</u> LSC _____	Correction Completed 04/22/2013	ID Prefix <u>A0081</u> Reg. # <u>58A-5.0191(2) FAC</u> LSC _____	Correction Completed 04/22/2013
ID Prefix <u>A0082</u> Reg. # <u>58A-5.0191(3) FAC</u> LSC _____	Correction Completed 04/22/2013	ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC _____	Correction Completed 04/22/2013	ID Prefix <u>A0152</u> Reg. # <u>58A-5.023(3) FAC</u> LSC _____	Correction Completed 04/22/2013
ID Prefix <u>A0161</u> Reg. # <u>58A-5.024(2) FAC</u> LSC _____	Correction Completed 04/22/2013	ID Prefix <u>A0167</u> Reg. # <u>58A-5.025(1) FAC</u> LSC _____	Correction Completed 04/22/2013	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
Reviewed By _____		Reviewed By _____		Date: _____	
State Agency _____		Signature of Surveyor: 		Date: <u>5/8/13</u>	
Reviewed By _____		Signature of Supervisor: 		Date: <u>5/8/13</u>	
CMS RO _____		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?		YES NO	
Followup to Survey Completed on: 2/20/2013					