

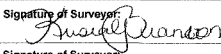
6/10/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967448	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 6/6/2013
Name of Facility CHANEL NURSING CARE ALF, CORP	Street Address, City, State, Zip Code 14111 SW 43 STREET MIAMI, FL 33175	

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>A0030</u> Reg. # <u>58A-5.0182(6) FAC: 429.28</u> LSC _____	Correction Completed 06/06/2013	ID Prefix <u>A0052</u> Reg. # <u>58A-5.0185(3) FAC</u> LSC _____	Correction Completed 06/06/2013	ID Prefix <u>A0074</u> Reg. # <u>58A-5.019(3)(b)</u> LSC _____	Correction Completed 06/06/2013
ID Prefix <u>A0079</u> Reg. # <u>58A-5.019(4) FAC</u> LSC _____	Correction Completed 06/06/2013	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed 06/06/2013	ID Prefix <u>A0152</u> Reg. # <u>58A-5.023(3) FAC</u> LSC _____	Correction Completed 06/06/2013
ID Prefix <u>A0161</u> Reg. # <u>58A-5.024(2) FAC</u> LSC _____	Correction Completed 06/06/2013	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	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____	Date: _____	Signature of Surveyor: 	Date: <u>06/10/2013</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: 4/9/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 12, 2013

Administrator
Chanel Nursing Care Alf, Corp
14111 Sw 43 Street
Miami, FL 33175

CCR#2013002805 f/u

Dear Administrator:

This letter reports the findings of a state complaint revisit survey conducted on June 6, 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.

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 Kristal Branton, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

for Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

J5XD

