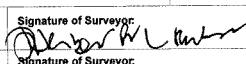
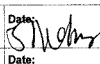


State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967941	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 5/15/2013
Name of Facility TROPICAL PARADISE		Street Address, City, State, Zip Code 1593 BRICKYARD ROAD CHIPLEY, FL 32428

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>A0026</u> Reg. # <u>58A-5.0182(2) FAC</u> LSC _____	Correction Completed 05/15/2013	ID Prefix <u>A0057</u> Reg. # <u>58A-5.0185(8) FAC</u> LSC _____	Correction Completed 05/15/2013	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	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 _____	Reviewed By _____	Date: _____	Signature of Surveyor: 	Date: _____	Signature of Surveyor: 
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____	Signature of Surveyor: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____	Signature of Surveyor: _____
CMS RO _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____	Signature of Surveyor: _____
Followup to Survey Completed on: 10/2/2012		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: AL11967941	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/15/2013
NAME OF PROVIDER OR SUPPLIER TROPICAL PARADISE			STREET ADDRESS, CITY, STATE, ZIP CODE 1593 BRICKYARD ROAD CHIPLEY, FL 32428		
(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 5/15/13 an unannounced revisit was conducted at Tropical Paradise Assisted Living Facility. At the time of the survey tags A0026 and A0057 were cleared. No new deficiencies were found at the time of the survey.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6892

YSQ613

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 16, 2013

Administrator
Tropical Paradise
1593 Brickyard Road
Chipley, FL 32428

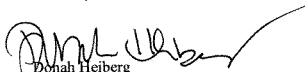
Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on May 15, 2013 by representative(s) of this office. Attached is the provider's copy of the Revisit Report, which indicates A0026 and A0057 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 Heiberg
Field Office Manager

DH/dh
Enclosure

J5XD

