

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11910951	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/5/2013
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Name of Facility DIVINE LIVING IN HIALEAH LLC	Street Address, City, State, Zip Code 70 EAST 21ST STREET HIALEAH, FL 33010
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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> Correction Completed Reg. # <u>58A-5.0182(6) FAC; 429.28</u> LSC <u> </u>	<u>07/05/2013</u>	ID Prefix <u>A0152</u> Correction Completed Reg. # <u>58A-5.023(3) FAC</u> LSC <u> </u>	<u>07/03/2013</u>	ID Prefix <u>A0160</u> Correction Completed Reg. # <u>58A-5.024(1) FAC</u> LSC <u> </u>	<u>07/05/2013</u>
ID Prefix <u> </u> Correction Completed Reg. # <u> </u> LSC <u> </u>	<u> </u>	ID Prefix <u> </u> Correction Completed Reg. # <u> </u> LSC <u> </u>	<u> </u>	ID Prefix <u> </u> Correction Completed Reg. # <u> </u> LSC <u> </u>	<u> </u>
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Reviewed By <u>C</u>	Reviewed By <u>Arline Mayo Davis</u>	Date: <u>7/5/13</u>	Signature of Surveyor: <u>for Arline Renter</u>	Date: <u>7/5/13</u>
State Agency <u> </u>	Reviewed By <u> </u>	Date: <u> </u>	Signature of Surveyor: <u> </u>	Date: <u> </u>
CMS RO <u> </u>				

Followup to Survey Completed on:

4/22/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

July 24, 2013

Administrator
Divine Living In Hialeah Llc
70 East 21st Street
Hialeah, FL 33010

CCR#2013004050 & 2013004185 f/u's

Dear Administrator:

This letter reports the findings of two state complaints revisit survey conducted on July 5, 2013 by representative(s) of this office.

Attached is the provider's copy of the State Form 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,

Arlene Mayo-Davis
Field Office Manager

AMD:sy
Enclosure

DT9D

