

AGENCY FOR HEALTH CARE  
ADMINISTRATION

PRINTED: 12/16/2013  
FORM APPROVED

|                                                                                                        |                                                                                                     |                                                     |
|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                                                              | (X1) PROVIDER/SUPPLIER<br>IDENTIFICATION NUMBER:<br><br><b>AL11911048</b>                           | (X3) DATE SURVEY COMPLETED<br><br><b>11/26/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>Seaside Healthcare</b>                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>2091 South Ocean Drive<br/>Hallandale, FL 33009</b> |                                                     |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) |                                                                                                     |                                                     |

**Revisit Corrected Tags:**

0030-Resident Care - Rights & Facility Procedures-11/26/2013



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

December 17, 2013

Administrator  
Seaside Healthcare  
2091 South Ocean Drive  
Hallandale, FL 33009

RE: CCR# 2013004228

Dear Administrator:

This letter reports the findings of a complaint survey revisit conducted on November 26, 2013 by a representative from this office. Attached is the provider's copy of the State Form (5000-3547), 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

  
Arlene Mayo-Davis  
Field Office Manager

AMD/dso  
Enclosure: State form 5000-3547

DT9D

