State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11967639	A. Building B. Wing	4/14/2015

Name of Facility	Street Address, City, State, Zip Code
HILL VIEW ASSISTED LIVING	3854 HIGHWAY 2 GRACEVILLE, FL 32440

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 A0010 Reg. # 429.26(1&9) FS; 58A-5.018 LSC	Correction Completed 04/14/2015	ID Prefix A0026 Reg. # 58A-5.0182(2) FAC LSC	Correction Completed 04/14/2015	ID Prefix A0052 Reg. # 58A-5.0185(3) FAC LSC	Correction Completed 04/14/2015
ID Prefix A0076 Reg. # 58A-5.0186 FAC LSC	Correction Completed 04/14/2015	ID Prefix A0083 Reg. # 58A-5.0191(4) FAC LSC	Correction Completed 04/14/2015	ID Prefix A0084 Reg. # 58A-5.0191(5) FAC LSC	Correction Completed 04/14/2015
ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed 04/14/2015	ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed 04/14/2015	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:
			[signature]	4/30/15
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/17/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967639	R **04/14/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
HILL VIEW ASSISTED LIVING	**3854 HIGHWAY 2 GRACEVILLE, FL 32440**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Revisit survey was conducted at Hill View Assisted Living Facility located in Graceville, FL on 4/14/2015. No deficient practice was identified during the survey.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 22, 2015

Administrator
Hill View Assisted Living
3854 Highway 2
Graceville, FL 32440

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on April 14, 2015 by representative(s) of 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 surveyor(s). Should you have any questions please call me at 850-412-4540.

Sincerely,

Donah Heiberg, MSW
Field Office Manager

DH/dh
Enclosure

DT9D

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