

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 05/26/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11910522	(X3) DATE SURVEY COMPLETED R 05/19/2015
NAME OF PROVIDER OR SUPPLIER SLC OF SORRENTO, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 336 MONET DRIVE NOKOMIS, FL 34275	

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

0000 - Initial Comments

An unannounced follow-up to Complaint Survey, CCR# 2014012479 was conducted on 5/19/15 at SLC Sorrento, an Assisted Living Facility (ALF) in Nokomis, Florida.

All deficiencies were found to be cleared at the time of the visit.

5/26/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11910522	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 5/19/2015
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Name of Facility

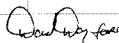
SLC OF SORRENTO, INC.

Street Address, City, State, Zip Code

336 MONET DRIVE
NOKOMIS, FL 34275

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 A0030 Reg. # 58A-5.0182(6) FAC: 429.28 LSC	Correction Completed 05/19/2015	ID Prefix A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed 05/19/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: 	Date: _____
State Agency _____	Reviewed By _____	Date: 5-26-15	Signature of Surveyor: LAURA OLIVO, DNS	Date: 5-26-15
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____				

Followup to Survey Completed on:

3/2/2015

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

May 26, 2015

Administrator
Slc Of Sorrento, Inc.
336 Monet Drive
Nokomis, FL 34275

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on May 19, 2015 by a representative 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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

