

5/28/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11968657	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 5/28/2015
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Name of Facility

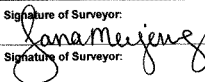
GRACE HOME LIVING FACILITY LLC

Street Address, City, State, Zip Code

2821 HUNT STR
JACKSONVILLE, FL 32254

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 <u>05/28/2015</u>	ID Prefix <u>A0030</u> Reg. # <u>58A-5.0182(6) FAC: 429.28</u> LSC _____	Correction Completed <u>05/28/2015</u>	ID Prefix <u>A0032</u> Reg. # <u>58A-5.0182(8) FAC</u> LSC _____	Correction Completed <u>05/28/2015</u>
ID Prefix <u>A0076</u> Reg. # <u>58A-5.0186 FAC</u> LSC _____	Correction Completed <u>05/28/2015</u>	ID Prefix <u>A0160</u> Reg. # <u>58A-5.024(1) FAC</u> LSC _____	Correction Completed <u>05/28/2015</u>	ID Prefix <u>A0161</u> Reg. # <u>429.275(2) FS: 58A-5.024(2)</u> LSC _____	Correction Completed <u>05/28/2015</u>
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: <u>5/28/15</u>
State Agency _____			Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____		Date: _____
CMS RO _____				

Followup to Survey Completed on:

4/23/2015

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 28, 2015

Administrator
Grace Home Living Facility LLC
2821 Hunt Street
Jacksonville, FL 32254

Dear Administrator:

This letter reports the findings of a state licensure desk review conducted on May 28, 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 desk review.

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 (904) 798-4201.

Sincerely,

A handwritten signature in dark ink, appearing to read "Jana Meyering".

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JM/sm
Enclosure

