

6/26/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11953224	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 06/25/2015
Name of Facility ANGELS GARDEN INC.		Street Address, City, State, Zip Code 8003 NORTH ROME AVENUE TAMPA, FL 33604

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>A0025</u> Reg. # <u>429.26(7) FS: 58A-5.0182(1)1</u> LSC _____	Correction Completed 06/25/2015	ID Prefix <u>A0026</u> Reg. # <u>58A-5.0182(2) FAC</u> LSC _____	Correction Completed 06/25/2015	ID Prefix <u>A0055</u> Reg. # <u>58A-5.0185(6) FAC</u> LSC _____	Correction Completed 06/25/2015
ID Prefix <u>A0081</u> Reg. # <u>58A-5.0191(2) FAC</u> LSC _____	Correction Completed 06/25/2015	ID Prefix <u>A0084</u> Reg. # <u>58A-5.0191(5) FAC</u> LSC _____	Correction Completed 06/25/2015	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed 06/25/2015
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	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
Reviewed By _____ State Agency	Reviewed By <u>[Signature]</u> Date: <u>6/29/15</u>	Signature of Surveyor: _____ Date: _____			Date: _____
Reviewed By _____ CMS RO	Reviewed By _____ Date: _____	Signature of Surveyor: _____ Date: _____			Date: _____
Followup to Survey Completed on: _____		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

June 30, 2015

Administrator
Angels Garden Inc.
8003 North Rome Avenue
Tampa, FL 33604

Dear Administrator:

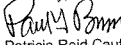
This letter reports the findings of a state licensure survey revisit conducted on June 25, 2015, by representative(s) of this office.

Attached is the provider's copy of the 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 **Paul Brown**, at (727) 552-2000.

Sincerely,

for 
Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: Revisit Report

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