

7/2/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11968079	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 6/29/2015
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Name of Facility BALMORE PLACE ASSISTED LIVING FACILITY	Street Address, City, State, Zip Code 14315 83RD LN N LOXAHATCHEE, FL 33470
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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>A0083</u> Reg. # <u>58A-5.0191(4) FAC</u> LSC _____	Correction Completed <u>06/29/2015</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	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 <u>WAL</u>	Reviewed By <u>WAL</u>	Date: <u>7/6/15</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>7/6/15</u>
State Agency		Date:	Signature of Surveyor:	Date:
Reviewed By _____	Reviewed By _____	Date:		
CMS RO				

Followup to Survey Completed on:
4/30/2015

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

July 6, 2015

Administrator
Baltimore Place Assisted Living Facility
14315 83rd Ln N
Loxahatchee, FL 33470

Dear Administrator:

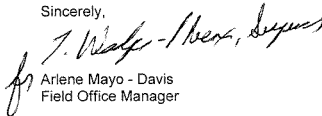
This letter reports the findings of a State Relicensure Revisit Survey conducted on June 29, 2015 by a representative from this office.

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.

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/jw
Enclosure

DT9D

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