State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11968108	A. Building B. Wing	7/1/2015

Name of Facility	Street Address, City, State, Zip Code
L & L ASSISTED LIVING COMMUNITY INC	4211 CHAIRES CROSS RD TALLAHASSEE, FL 32317

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 A0053 Reg. # 58A-5.0185(4) FAC LSC	Correction Completed 07/01/2015	ID Prefix A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed 07/01/2015	ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	Correction Completed 07/01/2015
ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed 07/01/2015	ID Prefix A0152 Reg. # 58A-5.023(3) FAC LSC	Correction Completed 07/01/2015	ID Prefix A0160 Reg. # 58A-5.024(1) FAC LSC	Correction Completed 07/01/2015
ID Prefix AL243 Reg. # 429.075(1) FS; 58A-5.0191(LSC	Correction Completed 07/01/2015	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

Reviewed By State Agency	**Reviewed By**	**Date:** 7/9/15	**Signature of Surveyor:** For Dale Tucker	**Date:** 7/9/15	
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**	

Followup to Survey Completed on: 5/11/2015

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
	AL11968108	R **07/01/2015**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
L & L ASSISTED LIVING COMMUNITY INC	**4211 CHAIRES CROSS RD TALLAHASSEE, FL 32317**	

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

0000 - Initial Comments

An unannounced revisit to the biennial survey (in conjunction with an extended congregate care monitoring survey) was conducted on 7/1/15 at L & L Assisted Living Facility. At the time of the revisit, all deficiencies were corrected.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

July 13, 2015

Administrator
L & L Assisted Living Community Inc
4211 Chaires Cross Rd
Tallahassee, FL 32317

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on July 1, 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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