

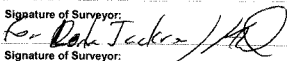
7/9/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11968108	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/1/2015
Name of Facility L & L ASSISTED LIVING COMMUNITY INC		Street Address, City, State, Zip Code 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 CMS RO	Reviewed By  Reviewed By	Date: 7/9/15 Date:	Signature of Surveyor:  Signature of Surveyor:	Date: 7/9/15 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		

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 07/09/2015
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11968108	(X3) DATE SURVEY COMPLETED R 07/01/2015
NAME OF PROVIDER OR SUPPLIER L & L ASSISTED LIVING COMMUNITY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 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

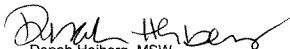
Dear Administrator:

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

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
Phone: 850-412-4540; Fax: (850) 922-9162
AHCA.MyFlorida.com



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