State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number
AL11965700

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
7/31/2015

Name of Facility
MAPLE LEAF ASSISTED LIVING FACILITY

Street Address, City, State, Zip Code
24 MEAD PLACE
STUART, FL 34997

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **A0081** Reg. # **58A-5.0191(2) FAC** LSC	**07/31/2015**	ID Prefix **A0085** Reg. # **58A-5.0191(6) FAC** LSC	**07/31/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency: N | Reviewed By: [signature] | Date: 8/10/15 | Signature of Surveyor: [signature] | Date: 8/10/15

Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date:

Followup to Survey Completed on:
6/4/2015

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

August 11, 2015

Administrator
Maple Leaf Assisted Living Facility
24 Mead Place
Stuart, FL 34997

RE: Monitoring Survey Revisit

Dear Administrator:

This letter reports the findings of a state monitoring survey revisit conducted on July 30, 2015 and July 31, 2015 by a representative 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. **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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

DT9D

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