

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11911325	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 10/26/2015
Name of Facility HPLS ASSISTED LIVING INC		Street Address, City, State, Zip Code 300 EAST KALEY AVENUE ORLANDO, FL 32806

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>A0162</u>	Correction Completed 10/26/2015	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>58A-5.024(3) FAC</u>	0162	Reg. # _____	ZZZZ	Reg. # _____	ZZZZ
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____	ZZZZ	Reg. # _____	ZZZZ	Reg. # _____	ZZZZ
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____	ZZZZ	Reg. # _____	ZZZZ	Reg. # _____	ZZZZ
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____	ZZZZ	Reg. # _____	ZZZZ	Reg. # _____	ZZZZ
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____	ZZZZ	Reg. # _____	ZZZZ	Reg. # _____	ZZZZ
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By <u>[Signature]</u>	Date: <u>10/30/15</u>	Signature of Surveyor: _____	Date: _____
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____				

Followup to Survey Completed on:

7/28/2015

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

October 30, 2015

Administrator
HPLS Assisted Living Inc
300 East Kaley Avenue
Orlando, FL 32806

RE: Revisit to relicensure w/LNS

Dear Administrator:

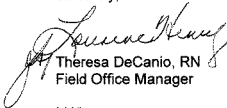
This letter reports the findings of a state licensure survey revisit conducted on October 26, 2015 by representative(s) of this office.

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.

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 Lorraine Henry at (407) 420-2502.

Sincerely,



Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

DT9D

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