

12/18/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11943004

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
12/18/2015

Name of Facility

COX ADULT LIVING FACILITY

Street Address, City, State, Zip Code

1906 Oscar Cox Trail
PLANT CITY, FL 33567

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
	Correction Completed 12/18/2015		Correction Completed 12/18/2015		Correction Completed
ID Prefix A0123		ID Prefix A0167		ID Prefix	
Reg. # 429.27(3-4) FS: 58A-5.021f; LSC		Reg. # 58A-5.025 FAC LSC		Reg. # LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. # LSC		Reg. # LSC		Reg. # LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. # LSC		Reg. # LSC		Reg. # LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. # LSC		Reg. # LSC		Reg. # LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By

State Agency

Reviewed By

CMS RO

Followup to Survey Completed on:

11/16/2015

Reviewed By

Reviewed By

Date:

Date:

Signature of Surveyor:

Signature of Surveyor:

Date:

Date:

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

December 18, 2015

Administrator
Cox Adult Living Facility
1906 Oscar Cox Trail
Plant City, FL 33567

Dear Administrator:

This letter reports the findings of a state licensure follow-up (desk review) conducted on December 18, 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 desk review.

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 **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

for Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosure: Revisit Report

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