

12/17/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11932431	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/15/2015
Name of Facility LOVING CARE LIVING FACILITY		Street Address, City, State, Zip Code 76 BRUEN STREET SAINT AUGUSTINE, FL 32095

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>A0078</u> Reg. # <u>58A-5.019(2) FAC</u> LSC _____	Correction Completed 12/15/2015	ID Prefix <u>A0161</u> Reg. # <u>429.275(2) FS: 58A-5.024(2)</u> LSC _____	Correction Completed 12/15/2015	ID Prefix <u>A0162</u> Reg. # <u>58A-5.024(3) FAC</u> LSC _____	Correction Completed 12/15/2015
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	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
Followup to Survey Completed on: 10/19/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			

Reviewed By _____

Reviewed By _____

Date: _____

Signature of Surveyor: _____

Date: _____

State Agency _____

Reviewed By _____

Date: _____

Signature of Surveyor: _____

Date: _____

CMS RO

Followup to Survey Completed on:

10/19/2015

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

December 17, 2015

Administrator
Loving Care Living Facility
76 Bruen Street
Saint Augustine, FL 32095

Dear Administrator:

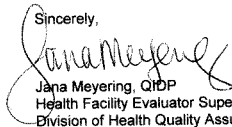
This letter reports the findings of a state licensure survey revisit conducted on December 15, 2015 by a representative of this office.

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. Should you have any questions please call this office at (904) 798-4201.

Sincerely,


Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

RS/JM/sm
Enclosure

DT9D

