



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 11, 2016

Administrator
Northpointe Retirement Community
5100 Northpointe Parkway
Pensacola, FL 32514

RE: CCR# 2015010423 & 2015011306

Dear Administrator:

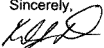
This letter reports the findings of a revisit complaint survey (2015010423) and a new complaint survey (2015011306) conducted on December 28, 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than February 11, 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite 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 850-412-4540.

Sincerely,


Donah Heiberg, M.S.W.
Field Office Manager

Enclosure DH/kb

BBT7

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**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 01/11/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911678	(X3) DATE SURVEY COMPLETED R 12/28/2015
NAME OF PROVIDER OR SUPPLIER NORTHPOINTE RETIREMENT COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 5100 NORTHPOINTE PARKWAY PENSACOLA, FL 32514	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

A follow-up complaint survey (CCR# 2015010423) was conducted on 12/28/15 at Northpointe ALF. In conjunction, a new unannounced complaint survey (CCR# 2015011306) was also conducted. Previously cited deficiencies were found corrected. Deficient practice was found associated with the new complaint at the time of the survey.

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11911678	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/28/2015
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Name of Facility

NORTHPOINTE RETIREMENT COMMUNITY

Street Address, City, State, Zip Code

5100 NORTHPOINTE PARKWAY
PENSACOLA, FL 32514

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>A0165</u> Reg. # <u>429.23(1-4 & 6-10) FS: 58A</u> LSC _____	Correction Completed 12/28/2015	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
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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 <i>[Signature]</i> Reviewed By	Date: <u>1/14/16</u> Date:	Signature of Surveyor: <i>for Norma Endrey/AD</i> Signature of Surveyor:	Date: <u>1/14/16</u> Date:
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Followup to Survey Completed on:

10/13/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO