STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968203 Y1	A. Building B. Wing Y2	1/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT JOSEPH ASSISTED LIVING FACILITY, INC	7615 BARRY RD TAMPA, FL 33615

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	A0010	Correction	ID Prefix	A0030	Correction	ID Prefix	A0078	Correction
Reg. #	429.26(1&9) FS; 58A-5.0181(4) FAC	Completed	Reg. #	58A-5.0182(6) FAC; 429.26(1-2) FS	Completed	Reg. #	58A-5.019(2) FAC	Completed
LSC		01/22/2016	LSC		01/22/2016	LSC		01/22/2016
ID Prefix	A0079	Correction	ID Prefix	A0081	Correction	ID Prefix		Correction
Reg. #	58A-5.019(3) FAC	Completed	Reg. #	58A-5.0191(2) FAC	Completed	Reg. #		Completed
LSC		01/22/2016	LSC		01/22/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	PSB	1/26/16		
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/23/2015	☐ YES ☐ NO

EVENT ID: Z65O12

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 27, 2016

Administrator
Saint Joseph Assisted Living Facility, Inc
7615 Barry Rd
Tampa, FL 33615

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on January 22, 2016 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 **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

PRC/clt
Enclosure: State Form (5000-3547),

DT9D

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