

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11968203	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/22/2016
NAME OF FACILITY SAINT JOSEPH ASSISTED LIVING FACILITY, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC LSC 01/22/2016	Correction Completed	ID Prefix A0030 Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS LSC 01/22/2016	Correction Completed	ID Prefix A0078 Reg. # 58A-5.019(2) FAC LSC 01/22/2016	Correction Completed
ID Prefix A0079 Reg. # 58A-5.019(3) FAC LSC 01/22/2016	Correction Completed	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC 01/22/2016	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 (INITIALS) <i>PSB</i>	DATE 1/26/16	SIGNATURE OF SURVEYOR		DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/23/2015		☐ 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

January 27, 2016

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

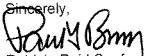
Dear Administrator:

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 Cauffman
Field Office Manager

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

DTSD

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