

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11967689	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 3/12/2016
NAME OF FACILITY GENTLE SHEPHERD ASSISTED LIVING FACILITY (THE)	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 WEST OAK STREET KISSIMMEE, FL 34741	

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 A0165	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 429.23(1-4 & 6-10) FS; 58A-5.0241 FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/12/2016	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	
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) <i>[Signature]</i>	DATE <i>3/12/16</i>	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/4/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 22, 2016

Administrator
Gentle Shepherd Assisted Living Facility (the)
1707 West Oak Street
Kissimmee, FL 34741

RE: Desk review to #2016001281

Dear Administrator:

This letter reports the findings of a state licensure complaint desk review conducted on March 12, 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 Lorraine Henry at (407) 420-2502.

Sincerely,

A handwritten signature in black ink, appearing to read "Theresa DeCanio".

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

DT9D

