| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11967375** | **03/02/2016** |
| NAME OF PROVIDER OR SUPPLIER<br>**TALLAHASSEE MEMORY CARE** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**2767 RAYMOND DIEHL ROAD**<br>**TALLAHASSEE, FL 32309** | |

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

**0000 Initial Comments**

An unannounced complaint survey for allegations contained within CCR#2016001482 was conducted in conjunction with a Biennial Survey with Limited Nursing Services at Tallahassee Memory Care Assisted Living from 3/1/16 through 3/2/16. At the time of survey the allegations were substantiated without deficient practice.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 15, 2016

**AMENDED to reflect a correction date of April 15, 2016**

Administrator
Tallahassee Memory Care
2767 Raymond Diehl Road
Tallahassee, FL 32309

**RE: CCR # 2016001482**

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted in conjunction with a complaint survey on March 2, 2016 by representatives 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 April 15, 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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,

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

DH/kc
Enclosure 2016001482

XG90

Tallahassee Field Office
2727 Mahan Drive, Mail Stop #46
Tallahassee, FL 32308
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