STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11968780 Y1	A. Building B. Wing Y2	8/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENS ASSISTED LIVING FACILITY (THE)	4122 W MAIN ST MIMS, FL 32754

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 A0052	Correction	ID Prefix A0078	Correction	ID Prefix A0079	Correction
Reg. # 58A-5.0185 (3)	Completed	Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.019(3) FAC	Completed
LSC	08/02/2016	LSC	08/02/2016	LSC	08/02/2016
ID Prefix A0081	Correction	ID Prefix A0152	Correction	ID Prefix A0162	Correction
Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.023(3) FAC	Completed	Reg. # 58A-5.024(3) FAC	Completed
LSC	08/02/2016	LSC	08/02/2016	LSC	08/02/2016
ID Prefix AZ814	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 435.12(2)(b-d), FS	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/02/2016	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	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE 8/8/16	SIGNATURE OF SURVEYOR	DATE
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? ☐ YES ☐ NO
5/19/2016	

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

August 8, 2016

Administrator
Gardens Assisted Living Facility (the)
4122 W Main St
Mims, FL 32754

RE: Revisit to Change of Ownership with Limited Nursing Services

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on August 2, 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,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

DT9D

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