

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11964733	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/31/2016
NAME OF FACILITY GRANDVIEW LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3250 DOUGLAS FERRY ROAD BONIFAY, FL 32425	

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 A0008	Correction	ID Prefix A0025	Correction	ID Prefix A0051	Correction
Reg. # 429.26(4-b) FS; 58A-5.0181(2) FAC	Completed	Reg. # 429.26(7) FS; 58A-5.0182(1) FAC	Completed	Reg. # 58A-5.0185(2) FAC	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix A0078	Correction	ID Prefix A0084	Correction	ID Prefix A0085	Correction
Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 58A-5.0191(6) FAC	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
ID Prefix A0093	Correction	ID Prefix AZ814	Correction	ID Prefix AZ815	Correction
Reg. # 58A-5.020(2) FAC	Completed	Reg. # 435.12(2)(b-d), FS	Completed	Reg. # 408.809, 435.02(2), 435.06	Completed
LSC	08/31/2016	LSC	08/31/2016	LSC	08/31/2016
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>R</i>	DATE 9/15/16	SIGNATURE OF SURVEYOR <i>R. G. L. L. Jackson</i>	DATE 9/15/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/6/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 09/15/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964733	(X3) DATE SURVEY COMPLETED R 08/31/2016
NAME OF PROVIDER OR SUPPLIER GRANDVIEW LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3250 DOUGLAS FERRY ROAD BONIFAY, FL 32425	

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

0000 Initial Comments

An unannounced revisit to the CHOW was conducted at Grandview Assisted Living Facility, license number 9275 on 8/31/16. At the time of survey the deficiencies were corrected.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 15, 2016

Administrator
Grandview Living
3250 Douglas Ferry Road
Bonifay, FL 32425

RE: CHOW (Change of Ownership)

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on August 31, 2016 by representatives of this office.

Attached is the provider's copy of the State Form, which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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/kb
Enclosure

DT9D

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