STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
AL11965485 Y1	A. Building B. Wing Y2	10/13/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL HEALTH CARE GROUP	10620 NW 32ND STREET SUNRISE, FL 33351

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 A0054	Correction	ID Prefix A0078	Correction
Reg. # 429.26(4-6) FS; 58A-5.0181(2) FAC	Completed	Reg. # 58A-5.0185(5) FAC	Completed	Reg. # 58A-5.019(2) FAC	Completed
LSC	10/13/2016	LSC	10/13/2016	LSC	10/13/2016
ID Prefix A0081	Correction	ID Prefix A0084	Correction	ID Prefix A0090	Correction
Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed	Reg. # 58A-5.0191(11) FAC	Completed
LSC	10/13/2016	LSC	10/13/2016	LSC	10/13/2016
ID Prefix A0161	Correction	ID Prefix A0167	Correction	ID Prefix	Correction
Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed	Reg. # 58A-5.025 FAC	Completed	Reg. #	Completed
LSC	10/13/2016	LSC	10/13/2016	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) W	DATE 10/5/16	SIGNATURE OF SURVEYOR	DATE 10/25/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 7/25/2016

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

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

October 25, 2016

Administrator
Professional Health Care Group
10620 Nw 32nd Street
Sunrise, FL 33351

Dear Administrator:

This letter reports the findings of a State Relicensure Revisit Survey conducted on October 13, 2016 by a representative from 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.

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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo - Davis
Field Office Manager

AMD/jw
Enclosure

DT9D

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