



RICK SCOTT  
GOVERNOR

JUSTIN M. SENIOR  
INTERIM SECRETARY

October 18, 2016

Administrator  
Hawthorn House  
1200 Hawthorn House Dr  
Shalimar, FL 32579

CCR# 2016006869

Dear Administrator:

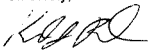
This letter reports the findings of a complaint survey revisit conducted by desk review on October 17, 2016 by a representative of this office.

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. Should you have any questions please call me at 850-412-4540.

Sincerely,

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

DH/kb  
Enclosure

DT9D

Tallahassee Field Office  
2727 Mahan Drive, Mail Stop #46  
Tallahassee, FL 32308  
Phone: 850-412-4540; Fax: (850) 922-9162  
[AHCA.MyFlorida.com](http://AHCA.MyFlorida.com)



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**AGENCY FOR HEALTH CARE  
ADMINISTRATION**

**PRINTED: 10/18/2016  
FORM APPROVED**

|                                                       |                                                                                                     |                                                             |
|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES                             | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11966523</b>                         | (X3) DATE SURVEY COMPLETED<br><b>R</b><br><b>10/17/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><b>HAWTHORN HOUSE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1200 HAWTHORN HOUSE DR</b><br><b>SHALIMAR, FL 32579</b> |                                                             |

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

**0000 Initial Comments**

A desk review revisit complaint survey (CCR# 2016006869) was completed on October 17, 2016 for Hawthorn House. Based on submitted evidence of correction and supporting documentation, deficiencies were found corrected.

# STATE FORM: REVISIT REPORT

|                                                                  |                                                                                       |                               |
|------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------|
| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>AL11966523 | MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                       | DATE OF REVISIT<br>10/17/2016 |
| NAME OF FACILITY<br>HAWTHORN HOUSE                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1200 HAWTHORN HOUSE DR<br>SHALIMAR, FL 32579 |                               |

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<br>Y4               | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 |
|--------------------------|------------|------------|------------|------------|------------|
| ID Prefix A0056          | Correction | ID Prefix  | Correction | ID Prefix  | Correction |
| Reg. # 58A-5.0185(7) FAC | Completed  | Reg. #     | Completed  | Reg. #     | Completed  |
| LSC                      | 10/17/2016 | 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        |            |
| ID Prefix                | Correction | ID Prefix  | Correction | ID Prefix  | Correction |
| Reg. #                   | Completed  | Reg. #     | Completed  | Reg. #     | Completed  |
| LSC                      |            | LSC        |            | LSC        |            |

|                             |                                     |                           |                  |                       |                  |
|-----------------------------|-------------------------------------|---------------------------|------------------|-----------------------|------------------|
| REVIEWED BY<br>STATE AGENCY | <input checked="" type="checkbox"/> | REVIEWED BY<br>(INITIALS) | DATE<br>10/18/16 | SIGNATURE OF SURVEYOR | DATE<br>10/18/16 |
| REVIEWED BY<br>CMS RO       | <input type="checkbox"/>            | REVIEWED BY<br>(INITIALS) | DATE             | TITLE                 | DATE             |

FOLLOWUP TO SURVEY COMPLETED ON 8/29/2016

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