STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
AL11963723	A. Building B. Wing	11/1/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHIPOLA HEALTH AND REHABILITATION CENTER	4294 THIRD AVENUE MARIANNA, FL 32446

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 A0078 Reg. # 58A-5.019(2) FAC LSC	Correction Completed 10/15/2016	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed 10/15/2016	ID Prefix A0084 Reg. # 58A-5.0191(5) FAC LSC	Correction Completed 10/15/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KC	DATE 11/1/16	SIGNATURE OF SURVEYOR Kristi Cummings	DATE 11/1/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/1/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: C7V612

GENCY FOR HEALTH CARE
DMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11963723	R 11/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHIPOLA HEALTH AND REHABILITATION CENTER	4294 THIRD AVENUE MARIANNA, FL 32446

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

0000 **Initial Comments**

On November 1, 20196, a desk review revisit survey was conducted for the licensure survey dated September 1, 2016 for Chipola Health and Rehabilitation Center Assisted Living Facility, license #5008. Based on an acceptable plan of correction and supporting documentation, deficiencies were corrected.

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

November 1, 2016

Administrator
Chipola Health And Rehabilitation Center
4294 Third Avenue
Marianna, FL 32446

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted by desk review on November 1, 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/kc
Enclosure

DT9D

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