

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11963723	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/1/2016
NAME OF FACILITY CHIPOLA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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
D Prefix A0078	Correction	ID Prefix A0081	Correction	ID Prefix A0084	Correction
Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(2) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed
LSC	10/15/2016	LSC	10/15/2016	LSC	10/15/2016
D Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
D Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
D Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
D Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
D 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	SIGNATURE OF SURVEYOR	DATE
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

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 11/01/2016
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963723	(X3) DATE SURVEY COMPLETED R 11/01/2016
NAME OF PROVIDER OR SUPPLIER CHIPOLA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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:

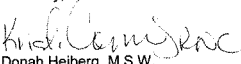
This letter reports the findings of a state licensure survey revisit conducted by desk review on November 1, 2016 by a representative of this office.

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

