

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11966560	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2	Y3
NAME OF FACILITY BAYAMO ASSISTED LIVING FACILITY, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1199 SW BAYAMO AVENUE PORT SAINT LUCIE, FL 34953	

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 A0030	Correction	ID Prefix A0078	Correction	ID Prefix A0084	Correction
Reg. # 58A-5.0182(6) FAC; 429.28(1-2) FS	Completed	Reg. # 58A-5.019(2) FAC	Completed	Reg. # 58A-5.0191(5) FAC	Completed
LSC		LSC		LSC	
ID Prefix A0161	Correction	ID Prefix AZ816	Correction	ID Prefix	Correction
Reg. # 429.275(2) FS; 58A-5.024(2) FAC	Completed	Reg. # 408.809(2)(a-c) FS	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 STATE AGENCY ☐	REVIEWED BY (INITIALS) <i>W</i>	DATE <i>11/22/16</i>	SIGNATURE OF SURVEYOR <i>[Signature]</i>		DATE <i>11/22/16</i>
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/30/2016		☐ 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

....., 2016

Administrator
Bayamo Assisted Living Facility, Inc
1199 SW Bayamo Avenue
Port Saint Lucie, FL 34953

Dear Administrator:

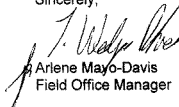
This letter reports the findings of a state licensure survey revisit conducted on 2016 by a representative of this office.

Attached is the provider's copy of the State Form, Revisit Report, 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,


Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure

DT9D

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