STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910538	**11/01/2016**
NAME OF PROVIDER OR SUPPLIER **ROBINSONS RESIDENTIAL CARE**	STREET ADDRESS, CITY, STATE, ZIP CODE **11921 CARUSO DRIVE** **PANAMA CITY, FL 32404**	

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

0000 Initial Comments

An unannounced complaint survey for allegations contained within CCR#2016011180 was conducted at Robinson Residential Care Assisted Living Facility (license number 7166) on 11/1/16. No deficient practice was identified at the time of survey.

TX Result Report

11/14/2016 16:50
Serial No. A5C0011007367
TC: 265530

Addressee	Start Time	Time	Prints	Result	Note
618505435853	11-14 16:49	00:00:57	000/002	No Ans	

Note TMR:Timer TX, POL:Polling, ORG:Original Size Setting, FME:Frame Erase TX, DPG:Page Separation TX, MIX:Mixed Original TX, CALL:Manual TX, CSRC:CSRC, FWD:Forward, PC:PC-FAX, BND:Double-Sided Binding Direction, SP:Special Original, FCODE:F-code, RTX:Re-TX, RLY:Relay, MBX:Confidential, BUL:Bulletin, SIP:SIP Fax, IPADR:IP Address Fax, I-FAX:Internet Fax

Result OK: Communication OK, S-OK: Stop Communication, PW-OFF: Power Switch OFF, TEL: RX from TEL, NG: Other Error, Cont: Continue, No Ans: No Answer, Refuse: Receipt Refused, Busy: Busy, M-Full:Memory Full, LOVR:Receiving length Over, POVR:Receiving page Over, FIL:File Error, DC:Decode Error, MDN:MDN Response Error, DSN:DSN Response Error, PRINT:Compulsory Memory Document Print, DEL:Compulsory Memory Document Delete, SEND:Compulsory Memory Document Send.

Mailed
11/15/16

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

November 14, 2016

Administrator
Robinsons Residential Care
11921 Caruso Drive
Panama City, FL 32404

RE: CCR #2016011180

Dear Administrator:

This letter reports the findings of a complaint survey completed on November 1, 2016 by representatives of this office.

Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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 surveyors. Should you have any questions, please contact me at 850-412-4540.

Sincerely,
Kris D. Cox RNC
FOR Donah Heiberg, M.S.W.
Field Office Manager

DH/kc
Enclosure

8JK1

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Sincerely,

Kim D. Combs RNC

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

DH/kc
Enclosure

8JK1

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