



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

January 3, 2017

Administrator
Laurelwood Assisted Living Facility, Inc
1851 West Ten Mile Road
Cantonment, FL 32533

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted by desk review on January 3, 2017 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,


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

DH/kb
Enclosure

DT9D

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**AGENCY FOR HEALTH CARE
ADMINISTRATION**

**PRINTED: 01/03/2017
FORM APPROVED**

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965123	(X3) DATE SURVEY COMPLETED R 01/03/2017
NAME OF PROVIDER OR SUPPLIER LAURELWOOD ASSISTED LIVING FACILITY, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1851 WEST TEN MILE ROAD CANTONMENT, FL 32533	

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

0000 - Initial Comments

A desk review revisit licensure survey was completed on January 3, 2017 for Laurelwood Assisted Living facility, license 9554. Based on submitted evidence of correction and supporting documentation, deficiencies were found corrected.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11965123	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/3/2017
NAME OF FACILITY LAURELWOOD ASSISTED LIVING FACILITY, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1851 WEST TEN MILE ROAD CANTONMENT, FL 32533	

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 AZ814	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 435.12(2)(b-d), FS	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/03/2017	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 STATE AGENCY ☒	REVIEWED BY (INITIALS) <i>Q</i>	DATE 1/3/17	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE 1/3/17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/17/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		