

Agency for Health Care Administration

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|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967802</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                       |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/14/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINDSOR OF PALM COAST</b> |                                                                                                                                                                          |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>50 TOWN COURT<br/>PALM COAST, FL 32164</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                             |                                                                                | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                            | Initial Comments<br><br>An initial Licensed Nursing Service survey was<br>conducted on September 14, 2012 at Windsor of<br>Palm Coast. There were no deficiencies found. |                                                                                | A 000                                                                                  |                                                                                                                          |                                                        |

AHCA Form 3020-0001

TITLE

(X8) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

5300

WTB711

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

September 17, 2012

Administrator  
Windsor of Palm Coast  
50 Town Court  
Palm Coast, FL 32164

Dear Administrator:

This letter reports findings of a state licensure Limited Nursing Services survey that was conducted on September 14, 2012 by a representative of this office. Attached is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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 surveyor. Should you have any questions please call this office at (904) 798-4201.

Sincerely,

  
for

Keisha Woods, MPH  
Health Facility Evaluator Supervisor  
Division of Health Quality Assurance

KJ/KW/sm  
Enclosure

