

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA /
Identification Number
AL11965241

(Y2) Multiple Construction
A. Building
B. Wing

(Y3) Date of Revisit
1/17/2013

Name of Facility

STANLEY HOUSE

Street Address, City, State, Zip Code

718 WALTON RD
DEFUNIAK SPRINGS, FL 32433

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
	Correction Completed		Correction Completed		Correction Completed
ID Prefix A0152	01/17/2013	ID Prefix		ID Prefix	
Reg. # 58A-5.023(3) FAC		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
	Correction Completed		Correction Completed		Correction Completed
ID Prefix		ID Prefix		ID Prefix	
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By

Reviewed By

Date:

Signature of Surveyor:

Date:

State Agency

Reviewed By

Date:

Signature of Surveyor:

Date:

CMS RO

Followup to Survey Completed on:

12/17/2012

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965241	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/17/2013
NAME OF PROVIDER OR SUPPLIER STANLEY HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 718 WALTON RD DEFUNIAK SPRINGS, FL 32433		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{A 000}	Initial Comments A desk review follow-up was completed. The previously cited deficiency was found to be corrected.	{A 000}		

AHCA Form 3020-0001

TITLE

(X8) DATE

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

STATE FORM

0000

M41612

If continuation sheet 1 of 1



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

February 6, 2013

Administrator
Stanley House
718 Walton Rd
Defuniak Springs, FL 32433

Dear Administrator:

This letter reports the findings of a desk review follow-up to the state licensure survey of December 17, 2012 (Spot check). Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were found corrected. **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 surveyors. Should you have any questions please call me at 850-412-4540.

Sincerely,


Patricia McIntire, Enc
Donah Heiberg, M.S.W.
Field Office Manager

DH/pm
Enclosure

J5XD

