

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11966561	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/25/2015
Name of Facility CARING PLACE (THE)		Street Address, City, State, Zip Code 2953 NW 10TH COURT FORT LAUDERDALE, FL 33311

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
ID Prefix <u>A0081</u> Reg. # <u>58A-5.0191(2) FAC</u> LSC _____	Correction Completed 10/02/2015	ID Prefix <u>A0082</u> Reg. # <u>58A-5.0191(3) FAC</u> LSC _____	Correction Completed 10/02/2015	ID Prefix <u>A0084</u> Reg. # <u>58A-5.0191(5) FAC</u> LSC _____	Correction Completed 10/02/2015
ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC _____	Correction Completed 10/02/2015	ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed 10/02/2015	ID Prefix <u>A0161</u> Reg. # <u>429.275(2) FS: 58A-5.024(2)</u> LSC _____	Correction Completed 10/02/2015
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u>TC</u> State Agency	Reviewed By <u>TC</u>	Date: <u>10/6/15</u>	Signature of Surveyor: <u>[Signature]</u>	Date: <u>10/6/15</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: 8/17/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

October 6, 2015

Administrator
Caring Place (The)
2953 NW 10th Court
Fort Lauderdale, FL 33311

Re: Desk Review

Dear Administrator:

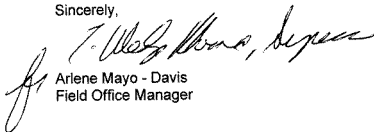
This letter reports the findings of State Licensure Revisit Survey conducted on September 25, 2015 by a representative from this office.

Attached are the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the revisit.

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/jw
Enclosure

J5XD

