



RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

January 4, 2017

Administrator
Residential Plaza At Blue Lagoon
5617 Nw 7 Street
Miami, FL 33126

Dear Administrator:

This letter reports the findings of a Complaint licensure survey revisit conducted on December 19, 2016 by representative(s) 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 to the surveyor(s). Should you have any questions please call Verlande Exil, Health Facility Evaluator Supervisor at (305) 593-3100.

Sincerely,

Arlene Mayo-Davis, RN
Field Office Manager

AMD:ve
Enclosure

DT9D



STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11911395	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/19/2016
NAME OF FACILITY RESIDENTIAL PLAZA AT BLUE LAGOON	STREET ADDRESS, CITY, STATE, ZIP CODE 5617 NW 7 STREET MIAMI, FL 33126	

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 A0010	Correction	ID Prefix A0025	Correction	ID Prefix A0031	Correction
Reg. # 429.26(1&9) FS; 58A-5.0181(4) FAC	Completed	Reg. # 429.26(7) FS; 58A-5.0182(1) FAC	Completed	Reg. # 58A-5.0182(7) FAC	Completed
LSC	12/19/2016	LSC	12/19/2016	LSC	12/19/2016
ID Prefix A0054	Correction	ID Prefix A0055	Correction	ID Prefix A0056	Correction
Reg. # 58A-5.0185(5) FAC	Completed	Reg. # 58A-5.0185(6) FAC	Completed	Reg. # 58A-5.0185(7) FAC	Completed
LSC	12/19/2016	LSC	12/19/2016	LSC	12/19/2016
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) 	DATE 11-1-17	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP ON STATE AGENCY COMPLAINT COMPLETED ON 10/28/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		