

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968469	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/21/2026
NAME OF PROVIDER OR SUPPLIER TOUCH OF GRACE ASSISTED LIVING FACILITY, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3425 SW RIVERA STREET PORT SAINT LUCIE, FL 34953		
(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 revisit to the Relicensure with Limited Mental Health (LMH) survey was conducted by desk review on 05/21/2026 for Touch of Grace Assisted Living Facility, Inc. The previously cited deficiencies were found corrected at the time of the review.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE