



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 10, 2012

Administrator
Peterson Assisted Living Facility
1622 Silver Street
Jacksonville, FL 32209

Re: CCR #2012006754

Dear Administrator:

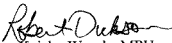
This letter reports the findings of a complaint survey completed on August 31, 2012 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction State (3020) Form, indicating no deficiencies were identified during this 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 contact this office at (904) 798-4201.

Sincerely,


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

CB/KW/sm
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
<http://ahca.myflorida.com>



Jacksonville Field Office
921 N. Davis St., Bldg. A, Suite 115
Jacksonville, FL 32209
Phone (904) 798-4201; Fax (904) 359-6054

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953610	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/31/2012
NAME OF PROVIDER OR SUPPLIER PETERSON ASSISTED LIVING FACIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1622 SILVER STREET JACKSONVILLE, FL 32209		
(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 complaint investigation, CCR #2012006754, was conducted at Peterson Assisted Living Facility on August 31, 2012. Deficiencies were not identified.	A 000			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5000

LH3K11

If continuation sheet 1 of 1