



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

September 14, 2012

Administrator
Summers Assisted Living Facility
1225 S.W. Grandview Avenue
Lake City, FL 32025

Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on September 11, 2012 by a representative of this office. Enclosed is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the 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 call this office at (386) 462-6201.

Sincerely,



Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964911	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/11/2012
NAME OF PROVIDER OR SUPPLIER SUMMERS ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 S.W. GRANDVIEW AVENUE LAKE CITY, FL 32025		
(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)
A 000	Initial Comments An LNS monitoring visit was made on 09/11/2012. The Summers Assisted Living Facility had no deficiencies found at the time of the visit as it applies to this survey only.	A 000	

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5850

T2YH11

If continuation sheet 1 of 1