

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 05/06/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11965962	(X3) DATE SURVEY COMPLETED 04/23/2015
NAME OF PROVIDER OR SUPPLIER MAGNOLIA RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE 4838 NW 93RD TERRACE SUNRISE, FL 33351	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced complaint inspection survey, CCR #2015000007, was conducted on 03/31/2015-04/23/2015 at Magnolia Residence Assisted Living Facility. The facility had no deficiencies identified at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 06, 2015

Administrator
Magnolia Residence
4838 NW 93rd Terrace
Sunrise, FL 33351

RE: CCR #2015000477

Dear Administrator:

This letter reports the findings of a complaint survey completed on March 31, 2015 and April 23, 2015 by a representative of this office. Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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 contact this office at (561) 381-5840.

Sincerely,


Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure

