STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968563	**09/01/2015**
NAME OF PROVIDER OR SUPPLIER **MORNING BREEZE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **5940 NW 19TH COURT** **LAUDERHILL, FL 33313**	

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

0000 Initial Comments

An unannounced Relicensure survey was conducted on 09/01/2015 at Morning Breeze Assisted Living Facility. The facility had no deficiencies found at the time of the visit.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 15, 2015

Administrator
Morning Breeze Assisted Living Facility
5940 Nw 19th Court
Lauderhill, FL 33313

Dear Administrator:

This letter reports findings of a state Relicensure survey that was conducted on September 1, 2015 by representative of this office. Attached is the provider's copy of the State (5000-3547) 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/sf
Enclosure

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