STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967749	**10/29/2015**
NAME OF PROVIDER OR SUPPLIER **ANGEL CARE ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **4301 31ST ST SOUTH** **SAINT PETERSBURG, FL 33712**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

A complaint survey (CCR 2015008681 and 2015010217) was conducted on 10/29/15 at the Angel Care Assisted Living Facility. No deficiencies were found at the time of the visit.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

November 10, 2015

Administrator
Angel Care Assisted Living Facility
4301 31st St South
Saint Petersburg, FL 33712

RE: CCR #2015008381 & 2015010217

Dear Administrator:

This letter reports the findings of a complaint survey completed on October 29, 2015 by representative(s) 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.

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(s). Should you have any questions, please contact **Paul Brown**, HFE Supervisor at (727) 552-2000.

Sincerely,

For Patricia Reid Caufman
Field Office Manager

PRC/aew
Enclosure: State (5000-3547) Form

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