STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11965292	**11/03/2015**
NAME OF PROVIDER OR SUPPLIER **ARDEN COURTS OF TAMPA**	STREET ADDRESS, CITY, STATE, ZIP CODE **14950 CASEY RD** **TAMPA, FL 33624**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY.

An Abbreviated Biennial Licensure Survey with Limited Nursing Services was conducted on 11/3/15 at the Arden Courts of Tampa.

No deficiencies were found at the time of this visit.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965292	A. BUILDING: _____ B. WING _____	11/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARDEN COURTS OF TAMPA	14950 CASEY RD TAMPA, FL 33624

(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 ASSISTED LIVING FACILITY. An Abbreviated Biennial Licensure Survey with Limited Nursing Services was conducted on 11/3/15 at the Arden Courts of Tampa. No deficiencies were found at the time of this visit.	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

November 18, 2015

Administrator
Arden Courts Of Tampa
14950 Casey Rd
Tampa, FL 33624

Dear Administrator:

This letter reports findings of a biennial state licensure survey with limited nursing services (LNS) that was conducted on November 3, 2015 by representative(s) 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 surveyor(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

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

1GGN

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