

AGENCY FOR HEALTH CARE  
ADMINISTRATION

PRINTED: 11/18/2015  
FORM APPROVED

|                                                                          |                                                                                               |                                                     |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11968932</b>                   | (X3) DATE SURVEY COMPLETED<br><br><b>11/17/2015</b> |
| NAME OF PROVIDER OR SUPPLIER<br><b>PERSON TO PERSON CARE CENTER, LLC</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6309 E FLORIDA CIR<br/>APOLLO BEACH, FL 33572</b> |                                                     |

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

**0000 Initial Comments**

ASSISTED LIVING FACILITY INITIAL LICENSURE SURVEY.

The Person to Person Care Center, LLC had no deficiencies found during the initial licensure survey of 11/17/15.

Agency for Health Care Administration

|                                                                              |                                                                                                                                                                                                             |                                                                                               |                                                                                                                          |
|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968932</b>                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                        | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/17/2015</b>                                                                   |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>PERSON TO PERSON CARE CENTER, LLC</b> |                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6309 E FLORIDA CIR<br/>APOLLO BEACH, FL 33572</b> |                                                                                                                          |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                | ID<br>PREFIX<br>TAG                                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |
| A 000                                                                        | Initial Comments<br><br>ASSISTED LIVING FACILITY INITIAL<br>LICENSURE SURVEY.<br><br>The Person to Person Care Center, LLC had no<br>deficiencies found during the initial licensure<br>survey of 11/17/15. | A 000                                                                                         |                                                                                                                          |

AHCA Form 3020-0001

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

TITLE

(X5) DATE



RICK SCOTT  
GOVERNOR  
ELIZABETH DUDEK  
SECRETARY

November 18, 2015

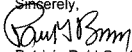
Administrator  
Person To Person Care Center, LLC  
6309 E Florida Cir  
Apollo Beach, FL 33572

Dear Administrator:

This letter reports the findings of an initial Licensure survey conducted on November 17, 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 Cauffman  
Field Office Manager

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

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