STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968701	**12/23/2015**
NAME OF PROVIDER OR SUPPLIER **CARING HANDS RESIDENCE LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **REDFIN DR, POINCIANA** **POINCIANA, FL 34759**	

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

0000 Initial Comments

Assisted Living Facility

On December 23, 2015, an extended congregate care (ECC) monitoring visit was conducted at Caring Hands Residence Assisted Living Facility. Deficient practice was not identified during the survey.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

January 20, 2016

Administrator
Caring Hands Residence LLC
Redfin Dr, Poinciana
Poinciana, FL 34759

Dear Administrator:

This letter reports findings of an extended congregate care (ECC) monitoring visit that was conducted on December 23, 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,

Teresa Ryan RN

for Patricia Reid Caufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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