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|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>AL11967815</b>                              | (X3) DATE SURVEY COMPLETED<br><br><b>02/09/2016</b> |
| NAME OF PROVIDER OR SUPPLIER<br><b>BRENNITY AT TRADITION (THE)</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>10685 SW STONEY CREEK WAY<br/>PORT SAINT LUCIE, FL 34987</b> |                                                     |

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

|                                                                                                                                                                                                       |                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| <b>0000</b>                                                                                                                                                                                           | <b>Initial Comments</b> |
| <p>An unannounced licensure complaint survey, CCR#2015011950, was conducted on February 9, 2016 at The Brennnity At Tradition. The facility had no deficiencies at the time of the investigation.</p> |                         |



RICK SCOTT  
GOVERNOR  
ELIZABETH DUDEK  
SECRETARY

February 22, 2016

Administrator  
Brennity At Tradition (The)  
10685 SW Stoney Creek Way  
Port Saint Lucie, FL 34987

**RE: CCR #2015011950**

Dear Administrator:

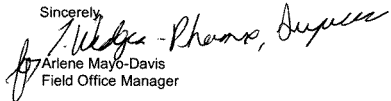
This letter reports the findings of a complaint survey completed on February 9, 2016 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiencies, State (5000-3547) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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 contact this office at (561) 381-5840.

Sincerely,

  
Arlene Mayo-Davis  
Field Office Manager

AMD/dso  
Enclosure: 5000-3547 form

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