

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953618	(X3) DATE SURVEY COMPLETED 02/29/2016
NAME OF PROVIDER OR SUPPLIER ABSOLUTE CARE ALF	STREET ADDRESS, CITY, STATE, ZIP CODE 3621 NW 90TH TERRACE SUNRISE, FL 33351	

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

0000 Initial Comments

An unannounced Change of Ownership survey was conducted on 2/29/2016 at Absolute Care ALF. The facility had no deficiencies at the time of the visit.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

March 10, 2016

Administrator
Absolute Care ALF
3621 NW 90th Terrace
Sunrise, FL 33351

Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on February 29, 2016 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 representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,


Arlene Mayo-Davis
Field Office Manager

AMD/dmb

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