STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968987	**04/01/2016**
NAME OF PROVIDER OR SUPPLIER **ASTORIA ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **319 ELDRIDGE AVE** **ORANGE PARK, FL 32073**	

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

0000 Initial Comments

On April 1, 2016 an initial licensure survey was conducted at Astoria Assisted Living. Deficient practice was not identified during the survey.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 5, 2016

Administrator
Astoria Assisted Living Facility
319 Eldridge Avenue
Orange Park, FL 32073

Dear Administrator:

This letter reports the findings of an initial Licensure survey conducted on April 1, 2016 by a representative 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. Should you have any questions please call this office at (904) 798-4201.

Sincerely,

Jana Meyering, QIDP
Health Facility Evaluator Supervisor
Division of Health Quality Assurance

JG/JM/sm
Enclosure

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