STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968231	04/06/2016
NAME OF PROVIDER OR SUPPLIER **DEBRA'S ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **1314 E LOUISE AVE** **SEMINOLE HEIGHTS, FL 33603**	

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

0000 Initial Comments

ASSISTED LIVING FACILITY

On April 6, 2016 a biennial re-licensure survey with limited mental health services (LMH) was conducted at Debra's Assisted Living Facility. There was no deficient practice identified during the surveys.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 14, 2016

Administrator
Debra's Assisted Living Facility
1314 E Louise Ave
Seminole Heights, FL 33603

Dear Administrator:

This letter reports findings of a biennial state licensure survey with limited mental health (LMH) that was conducted on April 6, 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 surveyor(s). Should you have any questions please call **Paul Brown**, HFES at (727) 552-2000.

Sincerely,

for Patricia Reid Caufman
Field Office Manager

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

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