

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 05/16/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967137	(X3) DATE SURVEY COMPLETED R 04/13/2016
NAME OF PROVIDER OR SUPPLIER A-1 ASSISTED LIVING FACILITY LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9410 SW 52 TERRACE MIAMI, FL 33165	

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

0000 Initial Comments

A Standard Biennial Revisit Survey was conducted on 04/13/16. A-1 Assisted Living Facility LLC, had deficiencies at the time of the survey, cited under Complaint Survey (CCR# 201002427).



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 16, 2016

Administrator
A-1 Assisted Living Facility Llc
9410 Sw 52 Terrace
Miami, FL 33165

Dear Administrator:

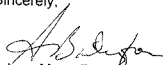
This letter reports the findings of a state licensure survey revisit conducted on April 13, 2016 by representative(s) of this office.

Attached is the provider's copy of the State Form (5000-3547). Deficiencies identified were cited under the complaint inspection (CCR #2016002427).

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 Sonia Bailey, Health Facility Evaluator Supervisor at (850) 412-4501.

Sincerely,


Arlene Mayo-Davis, RN
Field Office Manager

AMD/sb
Enclosure

DT9D

