AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968771	**06/13/2016**
NAME OF PROVIDER OR SUPPLIER **SKAGWAY LIVING FACILITY, LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **2210 W SKAGWAY AVE TAMPA, FL 33604**	

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

0000 Initial Comments

Assisted Living Facility

An unannounced Complaint survey (CCR# 2016003400) was conducted at the facility on 6/13/16.

The Skagway Living Facility LLC, Assisted Living Facility (License #12613), had no deficiencies at the time of this visit.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 22, 2016

Administrator
Skagway Living Facility, LLC
2210 W Skagway Ave
Tampa, FL 33604

RE: CCR #2016003400

Dear Administrator:

This letter reports the findings of a complaint survey completed on June 13, 2016 by representative(s) 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.

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 contact **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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