

AGENCY FOR HEALTH CARE
ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968705	(X3) DATE SURVEY COMPLETED 09/14/2016
NAME OF PROVIDER OR SUPPLIER SANTA SUSANA ASSISTED LIVING FACILITY INC	STREET ADDRESS, CITY, STATE, ZIP CODE 11407 LARKWOOD WAY TAMPA, FL 33625	

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

0000 Initial Comments

Assisted Living Facility

On 9/14/16, a biennial re-licensure state survey was conducted at Santa Susana Assisted Living Facility. Santa Susana Assisted Living Facility had no deficient practice identified during the survey.

(License # 12568)



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

September 22, 2016

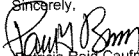
Administrator
Santa Susana Assisted Living Facility Inc.
11407 Larkwood Way
Tampa, FL 33625

Dear Administrator:

This letter reports findings of a biennial state licensure survey that was conducted on September 14, 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,

Patricia Reid-Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

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