STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968759	**11/17/2016**
NAME OF PROVIDER OR SUPPLIER **ASSURED CARE ALF**	STREET ADDRESS, CITY, STATE, ZIP CODE **12209 MATCHFIELD WAY** **RIVERVIEW, FL 33579**	

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

0000 Initial Comments

Assisted Living Facility

A biennial survey conducted at Assured Care Assisted Living Facility on 11/17/2016. Assured Care Assisted Living Facility had no deficient practice identified during survey.

License: 12602

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

November 30, 2016

Administrator
Assured Care ALF
12209 Matchfield Way
Riverview, FL 33579

Dear Administrator:

This letter reports findings of a biennial state licensure survey that was conducted on November 17, 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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