STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968630	**11/29/2016**
NAME OF PROVIDER OR SUPPLIER **OSPREY HEALTH CARE CENTER LLC**	STREET ADDRESS, CITY, STATE, ZIP CODE **6775 40TH AVE NORTH** **SAINT PETERSBURG, FL 33709**	

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

0000 Initial Comments

Assisted Living Facility

A complaint survey, (CCR# 2016011187) was conducted at Osprey Health Care Health on 11/29/2016. Osprey Health Care Center, Assisted Living Facility, had no deficiencies identified at the time of the visit.

(License # 12498)

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

December 7, 2016

Administrator
Osprey Health Care Center LLC
6775 40th Ave North
Saint Petersburg, FL 33709

RE: CCR# 2016011187

Dear Administrator:

This letter reports the findings of a complaint survey completed on November 29, 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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-basec 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 Cauffman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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