STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911318	R **02/10/2017**
NAME OF PROVIDER OR SUPPLIER **ISLANDS ALF (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **901 NORTH HIAWASSEE ROAD** **ORLANDO, FL 32818**	

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

0000 - Initial Comments

2/10/17 desk review to re-licensure survey with Limited Nursing Services and Limited Mental Health was completed. There were no deficiencies at the time of the review.

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