| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11966361** | R<br>**02/16/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**CAREGIVERS TOUCH, A.L.F.** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**4536 W IDLEWILD AVE**<br>**TAMPA, FL 33614** | |

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

**0000 - Initial Comments**

Assisted Living Facility

A follow-up visit to 1/3/17 abbreviated survey with limited mental health (LMH) was conducted at Caregivers Touch ALF on 2/16/17. The deficient practice previously cited on 1/3/17 was corrected during the visit.

(License number 10588).