STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968780	R **01/23/2017**
NAME OF PROVIDER OR SUPPLIER **GARDENS ASSISTED LIVING FACILITY (THE)**	STREET ADDRESS, CITY, STATE, ZIP CODE **4122 W MAIN ST** **MIMS, FL 32754**	

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

0000 - Initial Comments

1/23/17 desk review completed to Extended Congregate Care and Limited Nursing Services monitoring visit. There were no deficiencies at the time of the survey review.