

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 05/10/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967962	(X3) DATE SURVEY COMPLETED R 05/01/2017
NAME OF PROVIDER OR SUPPLIER TRANSITION CARE ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1613 SW MERIDIAN AVE PORT SAINT LUCIE, FL 34953	

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

0000 - Initial Comments

An unannounced second revisit to the relicensure survey was conducted on 05/01/2017 at Transition Care Assisted Living Facility, License # 11948. The facility had no deficiencies identified at the time of the survey, previously cited deficiencies were found corrected.