| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11968964** | **08/22/2017** |
| NAME OF PROVIDER OR SUPPLIER<br>**SUMMER VISTA ASSISTED LIVING COMMUNITY** | STREET ADDRESS, CITY, STATE, ZIP CODE<br>**3450 WIMBLEDON DR**<br>**PENSACOLA, FL 32504** | |

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

**0000 - Initial Comments**

A licensure survey with Change of Ownership, Extended Congregate Care (ECC) and Limited Nursing Services ( LNS) survey was conducted at Summer Vista Assisted Living Facility on 8/2217. At the time of survey the facility did not have deficient practice.