STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967962	R **03/19/2018**
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

A Change of Ownership (CHOW) survey second revisit was conducted by desk review on 03/07/18 and 03/19/18 for Transition Care Assisted Living Facility, License #11948. All outstanding deficiencies were corrected.