AGENCY FOR HEALTH CARE ADMINISTRATION

PRINTED: 04/01/2019
FORM APPROVED

| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X3) DATE SURVEY COMPLETED |
|---|---|---|
| | **AL11969149** | R<br>**03/28/2019** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **TROUT RIVER ASSISTED LIVING FACILITY** | **9821 RIBAULT AVE**<br>**JACKSONVILLE, FL 32208** |

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

**0000 - Initial Comments**

All of the deficienices were corrected at the time of the desk review.