STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967962	**05/28/2019**
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 Generator Assessment Monitoring survey was conducted at at Transition Care ALF on 05/28/19. The Provider had no deficiencies at the time of the visit.