

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967749	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/01/2019
NAME OF PROVIDER OR SUPPLIER ANGEL CARE ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 4301 31ST ST SOUTH SAINT PETERSBURG, FL 33712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 000}	Initial Comments A second revisit to a complaint investigation (complaint numbers 2019006762, 2019003267 and 2019002748) was conducted at Angel Care Assisted Living Facility on 11/1/2019. Deficiencies were found to be corrected at the time of the survey.	{A 000}			

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE