

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969560	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/18/2020
NAME OF PROVIDER OR SUPPLIER YOURLIFE OF COCONUT CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 5461 JOHNSON RD COCONUT CREEK, FL 33073			
(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 An unannounced licensure Compliant survey (#2020008885) was conducted on 05/18/2020 at YourLife of Coconut Creek. The facility had no deficiencies identified at the time of the survey. An Infection Control Special survey was conducted in conjunction with the licensure complaint survey (#2020008885) on 05/18/2020 at YourLife of Coconut Creek. See separate report for findings.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE