

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                  |                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965709</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/21/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOOD SAM'S ASSISTED LIVING RESIDENCE, LLC</b> |                                                                                                                                                                                                                                                                                                                                      |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1 PEBBLEWOOD LANE<br/>PALM COAST, FL 32164</b>                               |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 000                                                                                | Initial Comments<br><br>A complaint investigation (complaint number 2020002254) along with a COVID-19 Infection Control Visit and Emergency Environmental Control Plan (EECP) monitoring survey was conducted at Good Sam's Assisted Living Residence, LLC on 7/21/2020. The provider had no deficiencies at the time of the survey. | A 000                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

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

TITLE

(X6) DATE