

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965383	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/23/2020
NAME OF PROVIDER OR SUPPLIER SAVANNAH COTTAGE OF LAKELAND			STREET ADDRESS, CITY, STATE, ZIP CODE 605 CARPENTERS WAY LAKELAND, FL 33809		
(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 complaint investigation (complaint number 2020000794) with a focused infection control and generator monitoring survey inconjunction with a revisit to the 6/15/2020 complaint investigation (complaint number 2020010129) with a focused infection control and generator monitoring survey was conducted at Savannah Cottage Of Lakeland on 07/23/2020. The provider had no deficiencies at the time of the visit.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE