

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/27/2020
NAME OF PROVIDER OR SUPPLIER LINDSAY'S ALTERNATIVE CARE, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 5783 NW 48TH DRIVE CORAL SPRINGS, FL 33067			
(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 Generator Assessment monitoring survey was conducted on 7/27/2020 at Lindsay's Alternative Care, Inc. The facility had no deficiencies at the time of the survey. This survey was conducted in conjunction with the Infection Control Special survey on the same day. See separate report for findings.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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