

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>AL11963902</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/03/2020</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>AMERICARE ASSISTED LIVING</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2992 DAY ROAD<br/>DELTONA, FL 32738</b> |
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| (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                    | <p>Initial Comments</p> <p>A complaint investigation (complaint number 2020004185) in conjunction with an Infection Control, and Generator monitoring visit was conducted at Americare Assisted Living Facility on 8/3/2020. The facility had no deficiencies at the time of the survey.</p> | A 000               |                                                                                                                          |                          |

AHCA Form 3020-0001  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE