Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969393	A. BUILDING: _____ B. WING _____	08/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPPING STONES ASSISTED LIVING FACILITY	183 SE COLUMBUS TRL MADISON, FL 32340

(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 On 8/05/2020 - 8/07/2020 a generator assessment and focus infection control survey was conducted at Stepping Stones ALF in Madison, Florida. The facility had signage prohibiting visitors and a portable generator. On site visits were made to the facility on 8/5/2020 at 10:00 AM 8/6/2020 at 8:30 AM and on 8/7/2020 at 9:00 AM. During all 3 visits, there were no staff or residents and the ALF appeared vacant. On 8/7/2020 at 9:45 AM, an interview was conducted with the administrator who confirmed that the ALF had no staff or residents. The administrator stated that they had not yet started admitting residents since initial licensure.	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE