

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968833	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/02/2020
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NAME OF PROVIDER OR SUPPLIER LOVING CARE OF THE TREASURE COAST, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SW LARCHMONT LANE PORT SAINT LUCIE, FL 34984
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(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 capacity increase survey was conducted on 09/02/2020 at Loving Care of the Treasure Coast LLC. The facility had no deficiencies at the time of the survey. This survey was conducted in conjunction with the Capacity increase survey on the same date. See separate report for findings.	A 000		

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

TITLE

(X6) DATE