

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965330	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/20/2020
NAME OF PROVIDER OR SUPPLIER ARCADIA OAKS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1013 EAST GIBSON STREET ARCADIA, FL 34266			
(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 revisit survey was conducted on 8/20/2020 at Arcadia Oaks, an assisted living facility in Arcadia, Florida. This was a follow-up to the complaint and focused infection control survey completed on 6/8/20. The previous deficiency was found corrected and no new deficiencies were identified.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE