

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/08/2021
NAME OF PROVIDER OR SUPPLIER S & R ASSISTED LIVING FACILITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 907 WOODLAND TERRACE BRANDON, FL 33511		
(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 A biennial re-licensure survey done in conjunction with a capacity increase, a focused infection control visit and a generator monitoring for S & R Assisted Living Facility on 2/8/21. The facility had no deficiencies at the time of survey.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE