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
	AL11964707	A. BUILDING: _____ B. WING _____	01/29/2021

NAME OF PROVIDER OR SUPPLIER

INDIGO PALMS

STREET ADDRESS, CITY, STATE, ZIP CODE

570 NATIONAL HEALTHCARE BLVD
DAYTONA BEACH, FL 32114

(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 focused infection control survey was conducted at Indigo Palms Assisted Living Facility on 01/29/2021. The facility had no deficiencies at the time of the survey.	A 000		

AHCA Form 3020-0001

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