

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964436	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/22/2020
NAME OF PROVIDER OR SUPPLIER HUNTER'S CROSSING PLACE-ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 4601 N.W. 53RD AVENUE GAINESVILLE, FL 32606		
(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 investigation, complaint numbers 2020014766 and 2020017957, and a COVID-19 focused infection control survey were conducted on December 21 - 22, 2020 at Hunter's Crossing Place Assisted Living. No deficiencies were identified.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE