

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11910722	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/13/2021
NAME OF PROVIDER OR SUPPLIER COLONIAL ASSISTED LIVING AT FORT LAUDERDALE		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 NW 55TH AVENUE LAUDERHILL, FL 33313			
(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 licensure Complaint survey, #2020006514, #2020011084, #2020016150, #2020019816, #2021000393, Focused Infection Control and Generator Assessment Monitoring survey was conducted on 04/12/2021 through 04/13/2021 at Colonial Assisted Living At Fort Lauderdale. 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