

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968855	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/30/2021
NAME OF PROVIDER OR SUPPLIER THE SPRINGS AT SOUTH BISCAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 6235 HOFFMAN ST NORTH PORT, FL 34287			
(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 3/29/21 through 3/30/21 at The Springs at South Biscayne, an assisted living facility in North Port Florida. This was a follow-up to the Focused Infection Control survey completed 1/14/21. The previous deficiency was found to be corrected at the time of survey	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE