

Agency for Health Care Administration

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|----------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                              |                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969147</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/01/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LASALLE ASSISTED LIVING ROCKLEDGE LLC</b> |                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3545 MURRELL RD<br/>ROCKLEDGE, FL 32955</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 000                                                                            | Initial Comments<br><br>A Complaint Investigation 2021007235 was<br>conducted at Harmony Villas One on 7/01/21.<br>The facility had a deficiency at the time of the<br>investigation however, the deficiency was recited<br>under Aspen IHGB12. | A 000                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

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

TITLE

(X6) DATE