

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969416	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/01/2022	
NAME OF PROVIDER OR SUPPLIER SHALLOW ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 9035 SHALLOW FORD LN PORT RICHEY, FL 34668		
(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 second revisit to a complaint investigation (Complaint # 2022002022) completed on 5/5/2022 and 6/27/2022 and was conducted at Shallow Assisted Living Assisted Living Facility on 08/01/2022. Deficiencies were found to be corrected at the time of survey. Amended	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE