

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>AL11965681</b>                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>03/29/2023</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANGELS SENIOR LIVING AT DUNEDIN</b> |                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3175 BELCHER ROAD</b><br><b>DUNEDIN, FL 34698</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 (# 2023001472) survey was<br>conducted at Angels Senior Living at Dunedin on<br>3/29/2023. The provider had no deficiencies at<br>the time of the visit. | A 000                                                                                         |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X6) DATE