

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966599	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/31/2023
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NAME OF PROVIDER OR SUPPLIER LUTHERAN HAVEN ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1525 HAVEN DR OVIEDO, FL 32765
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(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 capacity increase survey to 57 total between two buildings with Extended Congregate Care (ECC) was conducted at Lutheran Haven ECC on 2/22/23 and 3/31/23. The facility did not have deficiencies at the time of the onsite survey however, the outcome of the final results was pending receipt of a lease agreement.	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE