

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967240	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 11/20/2023
NAME OF PROVIDER OR SUPPLIER TORIA'S ASSISTED LIVING FACILITY II		STREET ADDRESS, CITY, STATE, ZIP CODE 613 FOREST HILLS DR BRANDON, FL 33510			
(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 revisit to 10/09/2023 biennial survey in conjunction with a revisit to 06/12/2023 complaint (complaint number 2023009122) survey was conducted at Toria's Assisted Living Facility II on 11/20/2023. The facility had no deficiencies at the time of survey.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE