

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11966523	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/04/2024
NAME OF PROVIDER OR SUPPLIER HAWTHORN HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 HAWTHORN HOUSE DR SHALIMAR, FL 32579			
(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 An unannounced biennial relicensure survey was conducted at Hawthorn House Assisted Living, an assisted living facility in Shalimar, FL, on 1/3/24-1/4/24. A review of the facility's limited nursing services, an assessment of the facility's generator, and a review of the facility's visitation policy were completed during this survey. No deficient practice was identified at the time of the survey.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE