

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965313	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 07/19/2024
NAME OF PROVIDER OR SUPPLIER THE CARLISLE ASSISTED LIVING AND MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 450 EAST OCEAN AVENUE LANTANA, FL 33462		
(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 revisit to the licensure Complaint survey (#2023017386, #2024002480) commenced on 07/16/2024 and concluded on 07/19/2024 at The Carlisle Assisted Living and Memory Care. The previously cited deficiencies were found corrected at the time of the survey.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE