Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11969945	A. BUILDING: _____ B. WING _____	R 10/24/2024

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE
ALL	ASSISTED LIVING FACILITY	1501 OLYMPIA AVE SW PALM BAY, FL 32908

(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
{CZ871}	408.806(7)(d) FS Attempted Inspection (d) If a provider is not available when an inspection is attempted, the application shall be denied. This Statute or Rule is not met as evidenced by: DEFICIENCY REMAINED UNCORRECTED The provider failed to be available when an inspection was attempted. Finding: On this surveyor arrived at the facility at 9:15am. Rang the doorbell twice and waited for a response. Called the facility and voice mail picked up. The mailbox was full. No cars were in the driveway and no lights were seen in the house. Left a business card with call and supervisor information on the door. Unclassified	{CZ871}		
{A 000}	Initial Comments A revisit for an addition of specialty license for Extended Congregate Care was attempted on at All Assisted Living Facility. Unable to complete the survey due to the facility remained empty.	{A 000}		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE