

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER TRUEWOOD BY MERRILL, PORT CHARLOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 AARON STREET PORT CHARLOTTE, FL 33952		
(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 complaint survey for complaints #2024010589, #2023023926, #2024005388, and #2023017528, was conducted 11/20/24 through 11/21/24, at Truewood by Merrill, Port Charlotte, an assisted living facility in Port Charlotte, Florida. Complaint #2024010589 was not substantiated. Complaint #2023012926 was not substantiated. Complaint #2024005388 was not substantiated. Complaint #2023017528 was not substantiated. There were no deficiencies found at the time of the visit.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE