

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969627	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/19/2024
NAME OF PROVIDER OR SUPPLIER THE EBENEZER ALF II LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 304 CHAUCER AVE LEHIGH ACRES, FL 33936			
(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 relicensure survey and complaint survey for #2024016053, #2024016526 and #2024011839 was conducted 12/18/24 through 12/19/24 at The Ebenezer II LLC, an assisted living facility in Lehigh Acres, Florida. Complaint # 2024016053 was substantiated without citation. Complaint # 2024016526 was substantiated without citation. Complaint # 2024011839 was substantiated without citation. No deficiencies were 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