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 |
|---|---|---|---|
| | AL11970027 | A. BUILDING: _____ B. WING _____ | R 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ROYAL VISTA ASSISTED LIVING INC | 4922/4924 JORDAN AVE S LEHIGH ACRES, FL 33973 |

| (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<br><br>A follow-up survey by desk review was conducted on 1/2/25 through 1/8/25, for Royal Vista Assisted Living Inc, an assisted living facility in Lehigh Acres, Florida.<br><br>The follow-up was in response to the complaint and emergency power plan monitoring survey completed on 9/12/24.<br><br>Based on the facility's plan of correction, and supporting documentation, the deficiencies were corrected as of 10/12/24, and no new deficiencies were identified.<br>. | {A 000} | | |

AHCA Form 3020-0001

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