

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/30/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER GRACE ASSISTED LIVING, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 22091 PEACHLAND BLVD PORT CHARLOTTE, FL 33954
---	---

(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 A follow-up survey by desk review was conducted on 4/25/25 through 4/30/25 for Grace Assisted Living LLC, an assisted living facility in Port Charlotte, Florida. The follow-up was in response to the relicensure, limited mental health, emergency power plan monitoring, health facility reporting system, and visitation form survey conducted on 2/27/25. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 3/27/25 and no new deficiencies were identified.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X8) DATE