

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11943002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/15/2025
NAME OF PROVIDER OR SUPPLIER GUARDIAN HOME ALF, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 431 E. AIRPORT BLVD. SANFORD, FL 32773		
(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 Monitoring visit was conducted on 05/15/25 for residents that were discharged from their previous facility due to closure. The facility was clean and free of clutter. The resident was happy and expressed that he did not want to leave the facility. The resident explained his children were happy with the move. The resident is adjusting well to his surroundings.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE