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
	AL11966350	A. BUILDING: _____ B. WING _____	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DR PHILLIPS ASSISTED LIVING FACILITY, INC	5412 PALM LAKE CIRCLE ORLANDO, FL 32819

(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 capacity increase and generator monitoring were conducted at Dr. Phillips Assisted Living Facility, Inc on 06/09/2025. There was no deficient practice found at the time of the visit. On 6/9/2025 at 10:00 AM, the tour of the facility began with the administrator to review the capacity to determine if there was adequate space. Observations revealed a total of 4 bedrooms. There were 2 private rooms with 1 bed in each room and the other two rooms housed double occupancy in both. The facility has 3 full bathrooms for the residents' use.	A 000		

AHCA Form 3020-0001

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