

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968108	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/03/2022
NAME OF PROVIDER OR SUPPLIER L & L ASSISTED LIVING COMMUNITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4211 CHAIRES CROSS RD TALLAHASSEE, FL 32317		
(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 On 3/3/2022, an unannounced closure monitoring survey was conducted at L & L Assisted Living Community, Inc. At the time of the survey, the provider was still in operation and had a total of 6 residents residing at the facility. The owner indicated she had no intention on closing the facility. The owner was provided a copy of the default final order dated 2/11/22 for not responding to an omissions notice and informed she had 30 days from the date of the notice to file an appeal.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE