

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967173	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/05/2012
NAME OF PROVIDER OR SUPPLIER SOUTHERN LIFESTYLE ALF OF LAKE PLACID		STREET ADDRESS, CITY, STATE, ZIP CODE 1297 US 27 NORTH LAKE PLACID, FL 33852		
(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 Assisted Living Facility A limited nursing services (LNS) state licensure survey was conducted 06/04/12 - 06/05/12 in conjunction with a complaint survey, see (Aspen Event DLBS11). Southern Lifestyle ALF of Lake Placid had no deficiencies found at the time of the visit. Deficiencies were cited relative to the complaint survey, see (Aspen Event DLBS11).	A 000		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

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GEW411

If continuation sheet 1 of 1

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

June 19, 2012

Administrator
Southern Lifestyle ALF of Lake Placid
1297 Us 27 North
Lake Placid, FL 33852

Dear Administrator:

Re: LNS licensure survey & CCR# 2012005189

This letter reports the findings of a limited nursing services (LNS) state licensure survey and a complaint survey that were conducted on June 4-5, 2012, by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified on the day of the visit relative to the complaint survey. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. Staff from this office will conduct a review to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call **Paul Brown**, HFES, at 727-552-2000.

Sincerely,

for Patricia Reid Cauffman
Field Office Manager

PRC/kpr

Enclosures: State Forms 3020

