

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/11/2019
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALEA ASSISTED LIVING FACILITY

**5304 NW 16TH STREET
LAUDERHILL, FL 33313**

(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 second revisit to the Relicensure survey was conducted by desk review on 09/11/19 for Alea Assisted Living Facility. The previously cited deficiency was found corrected at the time of the survey.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE