

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964654	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/09/2020
NAME OF PROVIDER OR SUPPLIER ST AUGUSTINE PLANTATION			STREET ADDRESS, CITY, STATE, ZIP CODE 2507 OLD ST. AUGUSTINE ROAD TALLAHASSEE, FL 32301		
(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 December 9, 2020 an unannounced complaint survey for allegations contained within complaint number 2020008290, 2020013913 and 2020014629 was conducted at St Augustine Plantation in Tallahassee, Fl. At the time of the survey deficient practice was not identified.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE