

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965181	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 05/02/2024
NAME OF PROVIDER OR SUPPLIER CYPRESS CREEK ASSISTED LIVING RESIDENCE INC		STREET ADDRESS, CITY, STATE, ZIP CODE 970 CYPRESS VILLAGE BLVD. RUSKIN, FL 33573			
(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 complaint investigation (#2024004221 and #2024005274) in conjunction with a generator monitoring visit was conducted at Cypress Creek Assisted Living Residence on 05/02/2024. No deficiencies were identified at the time of the visit.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE

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STREET ADDRESS, CITY, STATE, ZIP CODE

CYPRESS CREEK ASSISTED LIVING RESIDENCE INC

**970 CYPRESS VILLAGE BLVD.
RUSKIN, FL 33573**

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