

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/24/2025
NAME OF PROVIDER OR SUPPLIER QUEEN ELAINE ASSISTED LIVING FACILITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1210 QUEEN ELAINE DR CASSELBERRY, FL 32707		
(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 desk review for a re-licensure survey was conducted for Queen Elaine Assisted Living Facility LLC on 01/24/2025. The deficiencies found were corrected during the review.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE