

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969476	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/06/2025
NAME OF PROVIDER OR SUPPLIER MEDITERRANEAN ASSISTED LIVING FACILITY CORP			STREET ADDRESS, CITY, STATE, ZIP CODE 4427 MEDITERRANEAN RD LAKE WORTH, FL 33461		
(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 revisit to the Relicensure survey was conducted by desk review on 03/06/2025 for Mediterranean Assisted Living Facility Corp. The previously cited deficiencies were found correct at the time of the visit.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE