Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11966340 | A. BUILDING: _____ B. WING _____ | 07/29/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LEXINGTON MANOR ASSISTED LIVING | 20480 VETERANS BLVD PORT CHARLOTTE, FL 33954 |

| (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<br><br>An unannounced change of ownership, emergency power plan monitoring, health facility reporting system, visitation form, and complaint investigation for #2024012014 and #2024012489 was conducted at Lexington Manor Asssisted Living on 7/28/25 through 7/29/25.<br><br>Complaint #2024012014 was substantiated without citation.<br><br>Complaint #2024012489 was substantiated without citation.<br><br>The provider had no deficiencies at the time of survey.<br>. | A 000 | | |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE