

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 C 09/09/2026
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 An unannounced complaint survey for complaints 2026014904 and 2026014525 was conducted on 9/8/2026 - 9/9/2026 at St. Augustine Plantation Assisted Living Facility in Tallahassee, FL. A generator assessment was also performed during this survey. At the time of survey, no deficient practice was noted.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE