

Agency for Health Care Administration

|                                                              |                                                                                                                                                                                                                                                                    |                                                                                |                                                                                                                          |                          |                                                             |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969590</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br>R<br><b>01/21/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>CHATEAU MADELEINE</b> |                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>205 HARDOON LANE<br/>MELBOURNE, FL 32940</b>                                 |                          |                                                             |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                       | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                             |
| {A 000}                                                      | Initial Comments<br><br>A second revisit to a Complaint Investigation #2019017943 and an infection control assessment was conducted at Chateau Madeleine Assisted Living Facility on 1/21/2021. Deficiencies were found to be corrected at the time of the survey. | {A 000}                                                                        |                                                                                                                          |                          |                                                             |

AHCA Form 3020-0001

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

TITLE

(X6) DATE