

Agency for Health Care Administration

|                                                              |                                                                                                                                                                                                              |                                                                                        |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965048</b>         | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/28/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MADISON AT OVIEDO</b> |                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1725 PINE BARK PT<br/>OVIEDO, FL 32765</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 complaint investigation #2021006041 and<br>infection control monitoring were conducted at<br>Madison at Oviedo on 4/28/21. No deficiencies<br>were found at the time of the visit. | A 000                                                                                  |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X6) DATE