

Agency for Health Care Administration

|                                                     |                                                                                |                                                                        |                                                                    |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969897</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/27/2021</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**O.S.J. FAMILY PLACE ASSISTED LIVING FACILITY**

**2636 DAYBREEZE CT  
ORLANDO, FL 32839**

| (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>Desk Review was conducted on 12/27/2021.<br>Previous deficiencies were cleared as of<br>12/22/2021. O.S.J. Family Place Assited Living<br>Facility did not have any deficiencies at the time<br>of the review. | {A 000}             |                                                                                                                          |                          |

AHCA Form 3020-0001

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

TITLE

(X6) DATE