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
	AL11969100	A. BUILDING: _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOMEGUIN GARDEN ASSISTED LIVING LLC	107 CELAVA CT KISSIMMEE, FL 34743

(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 A re-licensure survey and generator monitoring was attempted on 12/17/24 at Tomeguin Garden Assisted Living Facility in Kissimmee. There was no one on the premises, so the re-licensure survey was unable to be conducted. A re-licensure survey and generator monitoring was attempted on 2/12/25 at Tomeguin Garden Assisted Living Facility in Kissimmee. There was no one on the premises, so the re-licensure survey was unable to be conducted. A re-licensure survey and generator monitoring was attempted on 3/26/25 at Tomeguin Garden Assisted Living Facility in Kissimmee. There was no one on the premises, so the re-licensure survey was unable to be conducted. A re-licensure survey and generator monitoring was conducted 4/7/25 at Tomeguin Garden Assisted Living Facility in Kissimmee. There were no deficiencies found at the time of the survey	A 000		

AHCA Form 3020-0001

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