

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964810	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/30/2025
NAME OF PROVIDER OR SUPPLIER BROOKDALE CONWAY		STREET ADDRESS, CITY, STATE, ZIP CODE 5501 EAST MICHIGAN STREET ORLANDO, FL 32822			
(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 3rd revisit to a re-licensure survey and Complaint Investigation #2024011036 was conducted at Brookdale Conway Assisted Living Facility and Memory Care with Limited Nursing Services (LNS) on 6/30/2025. Deficiencies were found to be corrected at the time of the survey visit.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE