

Agency for Health Care Administration

|                                                                |                                                                                                                                                                                                                                   |                                                                                              |                                                                                                                          |  |                                                                |
|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION            |                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967186</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>08/19/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANN'S HOUSE-OAKWOOD</b> |                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4407 MILLWOOD ROAD<br/>SPRING HILL, FL 34608</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>An unannounced follow-up to a re-licensure<br>survey was conducted by desk review for Ann's<br>House-Oakwood on August 19, 2025.<br>Deficiencies were found to be corrected at the<br>time of the review. | {A 000}                                                                                      |                                                                                                                          |  |                                                                |

AHCA Form 3020-0001

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

TITLE

(X8) DATE