

Agency for Health Care Administration

|                                                                          |                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |                          |                                                        |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11932406</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/12/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GREENLEAF ASSISTED LIVING LLC</b> |                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>509 W. VERONA STREET<br/>KISSIMMEE, FL 34741</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 #2025014605 and generator monitoring was conducted at Greenleaf Assisted Living, LLC. with Limited Mental Health (LMH) on 11/12/2025. The facility had no deficiencies 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