

Agency for Health Care Administration

|                                                                     |                                                                                                                                                                                                        |                                                                                             |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967442</b>              | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>12/15/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOLD CHOICE ORMOND BEACH</b> |                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1410 HAND AVENUE<br/>ORMOND BEACH, FL 32174</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 (complaint 2025008354)<br>was conducted at Gold Choice Ormond Beach on<br>12/15/2025. Deficiencies were not identified at<br>the time of the survey. | A 000                                                                                       |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE