

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/28/2026
NAME OF PROVIDER OR SUPPLIER MADISON AT OCOEE		STREET ADDRESS, CITY, STATE, ZIP CODE 80 NORTH CLARK RD OCOEE, FL 34761			
(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 second revisit to Complaint Investigation #2025013757 and Complaint Investigation #2025014736 (correction #2025014836) was conducted at Madison at Ocoee Assisted Living Facility and Memory Care with Limited Nursing Services (LNS) on 1/28/2026. 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