

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968834	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/08/2025
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NAME OF PROVIDER OR SUPPLIER BUFFALO CROSSINGS ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 3890 WOODRIDGE DR THE VILLAGES, FL 32162
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(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 An unannounced complaint investigation (complaint number 2025008865) was conducted at Buffalo Crossings Assisted Living Facility on July 8, 2025. The facility had no deficiencies at the time of the survey.	A 000		

AHCA Form 3020-0001

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

TITLE

(X8) DATE