

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969022	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/26/2024
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NAME OF PROVIDER OR SUPPLIER EXCELLENCE ASSISTED LIVING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 2250 S SEMORAN BLVD ORLANDO, FL 32822
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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 A revisit survey for complaint 2023009397 and 2023012994 was conducted at Excellence Assisted Living on 02/26/2024. The deficiencies were found to be corrected at the time of the visit.	{A 000}		

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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