Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11910284	A. BUILDING: _____ B. WING _____	10/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOLA PLACE A HOMEBRIDGE COMMUNITY ASS	301 SOUTH MAIN AVENUE MINNEOLA, FL 34715

(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 relicensure survey was conducted Minneola Place A Homebridge Community Assisted Living on October 06, 2026 through October 07, 2026. The provider had no deficiencies at the time of visit.	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE