

Agency for Health Care Administration

|                                                             |                                                                                                                                                                                                           |                                                                                         |                                                                                                                          |  |                                                        |
|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11967675</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>01/16/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>WINDSOR AT OCALA</b> |                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2650 SE 18TH AVENUE<br/>OCALA, FL 34471</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>An unannounced recertification survey was conducted at Windsor at Ocala on January 15 and January 16, 2025. The facility had no deficient praactice identified during the survey. | A 000                                                                                   |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE