

Agency for Health Care Administration

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|-----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                         |                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965252</b>            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/07/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BEST CARE SENIOR LIVING AT OCALA</b> |                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2300 S.W. 21ST CIRCLE<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 change of ownership licensure survey with Emergency Power Plan monitoring was conducted at Best Care Senior Living at Ocala on May 6, 2025 through May 7, 2025. The provider had no deficiencies at the time of the visit. | A 000                                                                                     |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE