

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969988	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 07/09/2025
NAME OF PROVIDER OR SUPPLIER ETERNALLY RICH ASSISTED LIVING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 218 DAFFODIL CIR TALLAHASSEE, FL 32305		
(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 On 7/9/25, an unannounced desk review follow up for the biennial survey, originally completed on 6/23/2025, was completed for Eternally Rich Assisted Living Facility in Tallahassee, FL. Based on interview and documentation, the previous deficiency was corrected.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE