

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

May 10, 2013

Administrator
Emeritus at Ocala East
1601 S.E. 24th Road
Ocala, FL 32671

Re: CCR #2013002726

Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on April 25, 2013 by representative(s) of this office. Enclosed is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at (386) 462-6201.

Sincerely,

Kriste J. Mennella
Field Office Manager

KJM/amw

Enclosure

65FO



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911441	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/25/2013
NAME OF PROVIDER OR SUPPLIER EMERITUS AT OCALA EAST		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 S.E. 24TH ROAD OCALA, FL 32671		
(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 04/25/2013 unannounced compliance survey CCR #2013002726 was conducted at Emeritus East Assisted Living Facility in Ocala Florida. No discernible deficiencies were identified as a result of this survey. The facility was in compliance at this time.	A 000		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

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If continuation sheet 1 of 1