

AGENCY FOR HEALTH CARE  
ADMINISTRATION

PRINTED: 12/02/2013  
FORM APPROVED

|                                                                                                        |                                                                                                   |                                                     |
|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES                                                                              | (X1) PROVIDER/SUPPLIER<br>IDENTIFICATION NUMBER:<br><br><b>AL11965659</b>                         | (X3) DATE SURVEY COMPLETED<br><br><b>11/25/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>Emerald Gardens Inc.</b>                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2159 McMullen Booth Road<br/>Clearwater, FL 33759</b> |                                                     |
| SUMMARY STATEMENT OF DEFICIENCIES<br>(FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION) |                                                                                                   |                                                     |

**Specific Tag Findings:**

0000-Initial Comments

Assisted Living Facility

An extended congregate care (ECC) monitoring visit was conducted on 11/25/213.

The Emerald Garden, Inc., assisted living facility, had no deficiencies at the time of the visit.



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

December 3, 2013

Administrator  
Emerald Gardens Inc.  
2159 McMullen Booth Road  
Clearwater, FL 33759

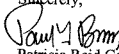
Dear Administrator:

This letter reports findings of an extended congregate care (ECC) monitoring visit that was conducted on November 25, 2013, by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) 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 **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,

  
for Patricia Reid Cauffman  
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

