STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966639	R **05/08/2018**
NAME OF PROVIDER OR SUPPLIER **CLOBRAN ASSISTED LIVING FACILITY**	STREET ADDRESS, CITY, STATE, ZIP CODE **3 CLEAR PLACE** **OCALA, FL 34476**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

A folow-up visit to a biennial survey was conducted at Clobran Assisted Living Facility on . . . . . At the time of the survey no deficiencies were identified.