

RICK SCOTT
GOVERNOR



ELIZABETH DUDEK
SECRETARY

August 27, 2012

Administrator
Emeritus At Ocala West
9070 SW 80th Ave
Ocala, FL 34481

Re: CCR #2012007515

Dear Administrator:

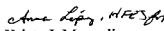
This letter reports the findings of a complaint survey completed on August 7, 2012 by representative(s) of this office.

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, State (3020) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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 contact Anna Lopez at (386) 462-6201.

Sincerely,


Kriste J. Mennella
Field Office Manager

KJM/al
Enclosure: State Form 3020

7MRZ



Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964969	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2012
NAME OF PROVIDER OR SUPPLIER EMERITUS AT OCALA WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 9070 SW 80TH AVE OCALA, FL 34481		
(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)
A 000	Initial Comments On 08/07/2012 an unannounced Assisted Living Facility (ALF) complaint survey was conducted. The facility was found to be in compliance with Chapter 429, Part I, F.S. and 58A-5, F.A.C.		A 000	

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

08/09

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If continuation sheet 1 of 1