

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/01/2020
NAME OF PROVIDER OR SUPPLIER SEASONS BELLEAIR		STREET ADDRESS, CITY, STATE, ZIP CODE 1145 PONCE DE LEON DRIVE BELLEAIR, FL 33756			
(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 A revisit to the complaint survey of 1/13/2020 in conjunction with a revisit to the focused infection control survey of 7/2/2020 and a complaint investigation (complaint numbers 2020001957, 2020009545 and 2020003636) with a Biennial survey was conducted at Seasons Belleair on 9/1/2020. The provider had no deficiencies at the time of the visit.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE