

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969278	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/04/2023
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ALL SEASONS IN NAPLES

**15450 TAMiami TrL N
NAPLES, FL 34110**

(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 An unannounced revisit survey was conducted on 4/4/23 at All Seasons in Naples, an assisted living facility in Naples, Florida. This was a follow-up to the complaint survey completed on 11/15/22. This survey was completed in conjunction with a relicensure, extended congregate care survey, Health Facility Reporting System, generator and visitation monitoring visit. The previous deficiencies were found corrected and no new deficiencies were identified.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE