



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

July 18, 2012

Administrator  
Ann's House Inc.  
6240 Bristol Lane  
Spring Hill, FL 34609

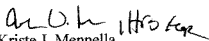
Dear Administrator:

This letter reports the findings of a Limited Nursing Services licensure survey that was conducted on July 11, 2012 by a representative of this office. Enclosed is the provider's copy of the State (3020) 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. Should you have any questions please call this office at (386) 462-6201.

Sincerely

  
Kriste J. Mennella  
Field Office Manager

KJM/amw

Enclosure



Agency for Health Care Administration

|                                                             |                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                          |
|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11966045</b>                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/11/2012</b>                                                                                                   |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANN'S HOUSE INC.</b> |                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>6240 BRISTOL LANE<br/>SPRING HILL, FL 34609</b> |                                                                                                                                                          |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)<br><br>(X5)<br>COMPLETE<br>DATE |
| A 000                                                       | Initial Comments<br><br>An unannounced Limited Nursing Services (LNS) monitoring visit was conducted on July 11, 2012. No deficiencies were identified during this survey. The Assisted Living Facility was found to be in compliance with Chapter 429, Part 1 & Chapter 408, Part II Florida Statutes and 58A-5 Florida Administrative Code as they apply to this survey only. | A 000                                                                                       |                                                                                                                                                          |

AHCA Form 3020-0001

TITLE

(X9) DATE

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

STATE FORM

0000

C11F11

If continuation sheet 1 of 1