

Agency for Health Care Administration

|                                                                         |                                                                                                                                                         |                                                                                |                                                                                                                          |  |                                                        |
|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                     |                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11911279</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/08/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ANN-WAY ASSISTED LIVING, INC</b> |                                                                                                                                                         |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8207 FOREST CITY ROAD<br/>ORLANDO, FL 32810</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) |  | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                                   | Initial Comments<br><br>A complaint inspection was completed on 10/8/12<br>for CCR #2012010898. There were no<br>deficiencies at the time of the visit. | A 000                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0099

O4U211

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

**Better Health Care for all Floridians**

ELIZABETH DUDEK  
SECRETARY

October 9, 2012

Administrator  
Ann-Way Assisted Living, Inc  
8207 Forest City Road  
Orlando, FL 32810

**Re: CCR #2012010898**

Dear Administrator:

This letter reports the findings of a complaint survey completed on October 8, 2012 by representative(s) of this office.

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, Form CMS-2567, and State (3020) Form, indicating no deficiencies were identified during this 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(s). Should you have any questions, please contact Lorraine Henry at (407) 420-2502.

Sincerely,



Theresa DeCanio, RM  
Field Office Manager

LH/be  
Enclosure

7MRZ

