

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968083</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                           |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>10/09/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AVOLON ASSISTED LIVING</b> |                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2580 FIRST STREET<br/>FORT MYERS, FL 33901</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                                                             | <p><b>Initial Comments</b></p> <p>This is an unannounced Limited Nursing Services (LNS) Monitoring survey, completed on 10/9/12, at Avalon Assisted Living, an Assisted Living Facility. The facility census at the time of the survey was seven residents.</p> <p>There are no residents receiving LNS services on the day of the survey. There are no discernable deficiencies identified during the survey.</p> |                                                                                | A 000                                                                                      |                                                                                                                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0050

R2LT11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

**Better Health Care for all Floridians**

ELIZABETH DUDEK  
SECRETARY

October 18, 2012

Administrator  
Avalon Assisted Living  
2580 First Street  
Fort Myers, Florida 33901

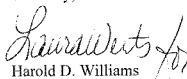
Dear Administrator:

This letter reports findings of a Limited Nursing Services survey that was conducted on October 9, 2012 by representative(s) of this office. Attached 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(s). Should you have any questions please call this office at (239) 335-1315.

Sincerely,

  
Harold D. Williams  
Field Office Manager

HW:ss  
Enclosure: State Form

