

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>AL11932406</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br><b>02/19/2013</b> |
|-----------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------|

|                                                                        |                                                                                              |
|------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ALL SEASONS ASSISTED LIVING</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>509 W. VERONA STREET<br/>KISSIMMEE, FL 34741</b> |
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| (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>Initial Comments</p> <p>2/19/2013 Limited Nursing Services (LNS)<br/>monitoring conducted.</p> <p>The facility had no deficiencies found pertaining<br/>to LNS</p> | A 000               |                                                                                                                          |                          |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0000

VWJ11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

**Better Health Care for all Floridians**

ELIZABETH DUDEK  
SECRETARY

March 22, 2013

Administrator  
All Seasons Assisted Living  
509 W. Verona Street  
Kissimmee, FL 34741

**Re: LNS monitoring**

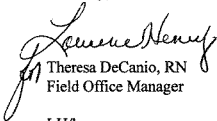
Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on February 19, 2013 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 Lorraine Henry at (407) 420-2502.

Sincerely,



Theresa DeCanio, RN  
Field Office Manager

LH/be  
Enclosure

