

Agency for Health Care Administration

|                                                                           |                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |  |                                                        |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                       |                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965334</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/28/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ARDEN COURTS OF WINTER SPRINGS</b> |                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1057 WILLA SPRINGS DRIVE<br/>WINTER SPRINGS, FL 32708</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>5/28/13 conducted Assisted Living Facility<br>complaint inspection CCR#2013002214 in<br>conjunction with the LNS monitoring visit.<br><br>There were no deficiencies found at the time of<br>the visit. | A 000                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5000

PJ6X11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

June 12, 2013

Administrator  
Arden Courts Of Winter Springs  
1057 Willa Springs Drive  
Winter Springs, FL 32708

**Re: CCR #2013002214**

Dear Administrator:

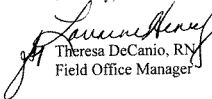
This letter reports the findings of a complaint survey completed on May 28, 2013 by representative(s) of this office.

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. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

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, RN  
Field Office Manager

LH/be  
Enclosure

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