

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER: AL11968663	(X3) DATE SURVEY COMPLETED 06/25/2014
NAME OF PROVIDER OR SUPPLIER Seasons Belleair	STREET ADDRESS, CITY, STATE, ZIP CODE 1145 Ponce De Leon Drive Belleair, FL 33756	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Specific Tag Findings:

0000-Initial Comments

An initial state licensure survey was conducted on 6/25/14.

Seasons Belleair, assisted living facility, had no deficiencies at the time of the visit.

A recommendation for a Standard license is being made at this time.



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 27, 2014

Administrator
Seasons Belleair
1145 Ponce De Leon Drive
Belleair, FL 33756

Dear Administrator:

This letter reports the findings of an initial state licensure survey conducted on June 25, 2014, by representative(s) of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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 **Paul Brown**, HFES, at (727) 552-2000.

Sincerely,



Patricia Reid Kaufman
Field Office Manager

PRC/kpr

Enclosure: State (5000-3547) Form

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