State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number: AL11932406

(Y2) Multiple Construction: A. Building / B. Wing

(Y3) Date of Revisit: 12/2/2015

Name of Facility: ALL SEASONS ASSISTED LIVING

Street Address, City, State, Zip Code: 509 W. VERONA STREET, KISSIMMEE, FL 34741

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0025 Reg. # 429.26(7) FS; 58A-5.0182(1 LSC	12/02/2015 0025	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	12/02/2015 0081	ID Prefix A0091 Reg. # 58A-5.0191(12) FAC LSC	12/02/2015 0091
ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	12/02/2015 0093	ID Prefix AL243 Reg. # 429.075(1) FS; 58A-5.0191(LSC	12/02/2015 L243	ID Prefix AZ816 Reg. # 408.809(2)(a-c) FS LSC	12/02/2015 Z816
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ
ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ	ID Prefix Reg. # LSC	ZZZZ

Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: Theresa DeCamp [signature] | Date: 12/4/15

Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date:

Followup to Survey Completed on: 9/8/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

December 4, 2015

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

RE: Revisit to relicensure survey

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on December 2, 2015 by representative(s) of this office.

Attached is the provider's copy of the State Form (5000-3547), which indicates the previously cited deficiencies were found corrected on the day of the revisit. **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 Lorraine Henry at (407) 420-2502.

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure

DT9D

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