

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 06/22/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968663	(X3) DATE SURVEY COMPLETED 06/15/2016
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 TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

Assisted Living Facility

An unannounced Biennial licensure survey was conducted on 6/15/16.

The Seasons Belleair, Assisted Living Facility (License #12532), had no deficiencies at the time of this visit.



RICK SCOTT
GOVERNOR
ELIZABETH DUDEK
SECRETARY

June 22, 2016

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

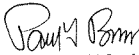
Dear Administrator:

This letter reports findings of a biennial state licensure survey that was conducted on June 15, 2016 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.

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,


for Patricia Reid Cauffman
Field Office Manager

PRC/clt
Enclosure: State (5000-3547) Form

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