STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968663	09/26/2016
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

A complaint investigation, (CCR# 2016007722), was conducted at Seasons Belleair on / . Seasons Belleair, had a deficiency at the time of the investigation.

(License number # 12532)

0160 Records - Facility

Based on interview and record review, the facility failed to maintain an up-to date admission and discharge log containing all required information.

Findings included:

The facility ' s admission and discharge log was requested during the entrance conference on . Staff A provided a document entitled " Move In/ Move Out Report " (Report). The Report was reviewed and revealed that it only contained the names of residents that moved in and moved out during the months of 2016 through 2016. Missing from the Report were the dates of admission and the facility or place which the residents were admitted from as required. The discharge portion of the Report did not contain the dates of discharge, the reason for discharge, or where the resident was discharged to as required.

An interview was conducted with the administrator and Staff A at 10:26 AM on concerning the missing information required on the admission/discharge log. The administrator acknowledged that required information was missing and stated that it would be corrected.

Class III

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

, 2016

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

RE: CCR# 2016007722

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016, by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiency. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiency identified on your survey, which may include a desk review or onsite revisit.

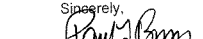
The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouragec and valued, as our goal is to ensure the professional and consistent application of the survey process.

St. Petersburg Field Office
525 Mirror Lake Drive North, Suite 410 A
St. Petersburg, FL 33701
Phone:(727) 552-2000; Fax:(727) 552-1162
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlidesShare.net/AHCAFlorida

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 Caufman
Field Office Manager

PRC/kpr

Enclosure: State Form 5000-3547

XG90