

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969827	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/10/2021
NAME OF PROVIDER OR SUPPLIER SARABELLA SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 5650 GANTT RD SARASOTA, FL 34233			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
A 000	Initial Comments An announced initial state licensure survey with extended congregate care services was conducted on 3/10/21 at Sarabella Senior Living, an assisted living facility in Sarasota, Florida. No deficiencies were identified at the time of the visit. Recommend licensure with ECC for a capacity of 134 beds effective 3/10/21.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE