

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911610	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/10/2024
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NAME OF PROVIDER OR SUPPLIER

PLYMOUTH HARBOR, INC.

STREET ADDRESS, CITY, STATE, ZIP CODE

**700 JOHN RINGLING BLVD
SARASOTA, FL 34236**

(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 A follow up survey by desk review was conducted on 5/10/24 for Plymouth Harbor, Inc., an assisted living facility in Sarasota, Florida. The follow up was in response to the survey completed on 3/21/24. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 4/13/2024.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE