Agency for Health Care Administration

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11967574 | A. BUILDING: _____ B. WING _____ | R 06/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TINA'S ALF | 1172 TARPON AVENUE SARASOTA, FL 34237 |

| (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<br><br>A follow-up survey by desk review was conducted on 6/12/24 at Tina's ALF, an assisted living facility in Sarasota, Florida. The follow-up was in response to the relicensure, emergency power plan, health facility reporting system, generator, and visitation form survey completed on 05/06/24.<br><br>Based on the corrective action plan and supporting documentation the deficiencies have been corrected. | {A 000} | | |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE