

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968928	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/13/2024
NAME OF PROVIDER OR SUPPLIER HARBORCHASE OF SARASOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 5311 PROCTOR 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 A follow-up survey by desk review was conducted on 12/6/24 through 12/13/24 for Harborchase Of Sarasota, an assisted living facility in Sarasota, Florida. The follow-up was in response to the Emergency power plan monitoring and complaint survey for #2023008997, #2023003526, #2024010031, #2024004684, and #2023003463 completed on 9/12/24. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 12/12/24 and no new deficiencies were identified.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE