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
	AL11953648	A. BUILDING: _____ B. WING _____	R 01/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE SARASOTA	4540 BEE RIDGE ROAD 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 unannounced revisit survey was conducted on 1/6/25, at American House Sarasota, an assisted living facility in Sarasota, Florida. This follow-up was in response to the complaint survey for #2023011707 & #2023013765 & #2023013796 & #2023016805 & #2024000426 & #2024009230 completed on 8/28/24 through 9/4/24. This survey was completed in conjunction with a new complaint survey. The previous deficiencies were found corrected, and no new deficiencies were identified at the time of the visit. .	{A 000}		

AHCA Form 3020-0001

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