

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 05/14/2026
NAME OF PROVIDER OR SUPPLIER MORNINGSIDE HOUSE OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 5851 N HONORE AVE SARASOTA, FL 34231		
(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 revisit by desk review to a relicensure, limited nursing service, emergency power plan monitoring, health facility reporting system and complaint survey was conducted for Morningside House of Sarasota on 5/7/26 through 5/14/26. Deficiencies were found to be corrected at the time of the survey.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE