

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911637	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/20/2012
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 3435 FOX RUN ROAD 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 This is the follow-up to the Biennial survey completed on 8/20/12 at Lakehouse West, an Assisted Living Facility. All previous citations have been substantially improved or corrected. No deficiencies were cited relevant to the survey during this visit.	{A 000}		

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

0099

JO5N12

If continuation sheet 1 of 1

8/28/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11911637	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/20/2012
Name of Facility LAKEHOUSE WEST	Street Address, City, State, Zip Code 3435 FOX RUN ROAD SARASOTA, FL 34231	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0055 Reg. # 58A-5.0185(6) FAC LSC	Correction Completed 08/20/2012	ID Prefix A0161 Reg. # 58A-5.024(2) FAC LSC	Correction Completed 08/20/2012	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor: <i>Laura for E. J. J. J.</i>	Date: 8/28/12
Followup to Survey Completed on: 6/5/2012	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

August 29, 2012

Administrator
Lakehouse West
3435 Fox Run Road
Sarasota, FL 34231

Dear Administrator:

This letter reports the findings of a Biennial survey revisit conducted on August 20, 2012 by a representative of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure

