

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11942812	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/02/2013
NAME OF PROVIDER OR SUPPLIER HORIZON BAY VIBRANT RET LIVING 449			STREET ADDRESS, CITY, STATE, ZIP CODE 730 SOUTH OSPREY AVENUE SARASOTA, FL 34236		
(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 These are the results of the follow-up survey, conducted on 4/2/13 to the Biennial survey which had been conducted on 1/22/13 through 1/23/13, at Horizon Bay Vibrant Retirement Living, an Assisted Living Facility (ALF), in Sarasota, Florida. 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

(X8) DATE

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

STATE FORM

8899

0ROM12

If continuation sheet 1 of 1

4/9/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11942812	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/2/2013
---	--	----------------------------------

Name of Facility

HORIZON BAY VIBRANT RET LIVING 449

Street Address, City, State, Zip Code

730 SOUTH OSPREY AVENUE
SARASOTA, FL 34236

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 <u>A0025</u> Reg. # <u>58A-5.0182(1) FAC</u> LSC _____	Correction Completed 04/02/2013	ID Prefix <u>A0030</u> Reg. # <u>58A-5.0182(6) FAC; 429.28</u> LSC _____	Correction Completed 04/02/2013	ID Prefix <u>A0051</u> Reg. # <u>58A-5.0185(2) FAC</u> LSC _____	Correction Completed 04/02/2013
ID Prefix <u>A0082</u> Reg. # <u>58A-5.0191(3) FAC</u> LSC _____	Correction Completed 04/02/2013	ID Prefix <u>A0088</u> Reg. # <u>429.177 FS</u> LSC _____	Correction Completed 04/02/2013	ID Prefix <u>A0090</u> Reg. # <u>58A-5.0191(11) FAC</u> LSC _____	Correction Completed 04/02/2013
ID Prefix <u>A0093</u> Reg. # <u>58A-5.020(2) FAC</u> LSC _____	Correction Completed 04/02/2013	ID Prefix <u>A0162</u> Reg. # <u>58A-5.024(3) FAC</u> LSC _____	Correction Completed 04/02/2013	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____	Reviewed By <u>Kris Vanderford, RN</u>	Date: <u>4-9-13</u>	Signature of Surveyor: <u>Kris Vanderford, RN</u>	Date: <u>4-9-13</u>
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
CMS RO _____				

Followup to Survey Completed on:

1/23/2013

Check for any Uncorrected Deficiencies. Was a Summary of
Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

April 9, 2013

Administrator
Horizon Bay Vibrant Ret Living 449
730 South Osprey Avenue
Sarasota, FL 34236

Dear Administrator:

This letter reports the findings of a state licensure survey revisit conducted on April 2, 2013 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

sh
Enclosures: State Form and Revisit Report

