

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965680	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/22/2013
NAME OF PROVIDER OR SUPPLIER AURORA MANOR, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2841 6TH STREET SARASOTA, FL 34237		
(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 On 4/22/13 a follow-up to the Biennial survey was completed at Aurora Manor an Assisted Living Facility (ALF). All previously cited deficiencies were found to be corrected. At the time of the survey no deficiencies were identified.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

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U34212

If continuation sheet 1 of 1

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11965680	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/22/2013
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Name of Facility AURORA MANOR, INC	Street Address, City, State, Zip Code 2841 6TH STREET SARASOTA, FL 34237
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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 A0030 Reg. # 58A-5.0182(6) FAC: 429.28 LSC	Correction Completed 04/22/2013	ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC	Correction Completed 04/22/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By HFE	Date: 4-30-13	Signature of Surveyor: Jon Alter, HFE II	Date: 4-30-13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/31/2012		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 30, 2013

Administrator
Aurora Manor, Inc
2841 6th Street
Sarasota, FL 34237

Dear Administrator:

This letter reports the findings of a Biennial survey revisit conducted on April 22, 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

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Enclosures: State Form and Revisit Report

