STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911637	**08/05/2014**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Lakehouse West	**3435 Fox Run Road Sarasota, FL 34231**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

Revisit Corrected Tags:
0025-Resident Care - Supervision-08/05/2014

On 8/05/14 a follow-up to the Biennial survey was completed at Lakehouse West an Assisted Living Facility (ALF).

All previously cited deficiencies were found to be corrected. At the time of the survey no deficiencies were identified.

0025-Resident Care - Supervision 58A-5.0182(1) FAC

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

August 12, 2014

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 5, 2014 by representative(s) of this office.

Attached is the provider's copy of the State Form (5000-3547), 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(s). 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: State Form

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