

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2013
NAME OF PROVIDER OR SUPPLIER ASHTON PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 4151 ASHTON ROAD SARASOTA, FL 34233		
(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 an unannounced 2nd follow up to Complaint survey, CCR# 2012009010, conducted on 2/5/13 at Ashton Place, an Assisted Living Facility in Sarasota Florida. The previously cited deficiency was noted to be cleared during the time of the revisit survey.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

6890

M5YL13

If continuation sheet 1 of 1

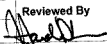
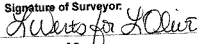
2/12/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11953701	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 2/5/2013
Name of Facility ASHTON PLACE		Street Address, City, State, Zip Code 4151 ASHTON ROAD SARASOTA, FL 34233

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 A0052 Reg. # 58A-5.0185(3) FAC LSC	Correction Completed 02/05/2013	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  Reviewed By	Date: 2-15-13 Date:	Signature of Surveyor:  Signature of Surveyor:	Date: 2-12-13 Date:
Followup to Survey Completed on: 9/25/2012		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

February 15, 2013

Administrator
Ashton Place
4151 Ashton Road
Sarasota, Florida 34233

Dear Administrator:

This letter reports the findings of a complaint survey 2nd revisit conducted on February 5, 2013 by representative of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiency was 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

HW:ss
Enclosures: State Form and Revisit Report

