## PRINTED: 07/03/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED ST

CENTERS FOR MEDICARE & MEDICAID SERVICES					
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
			С		
	105389	B. WING	06/13/2018		
A A AND TO SEE THE SEE SEED AND THE SEED AND		AMBREW - BARRAG COM - GWARE THE CARR			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3250 12TH ST HEARTLAND HEALTH CARE CENTER - NORTH SARASOTA SARASOTA, FL 34237 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY) F 000 INITIAL COMMENTS F 000 An unannounced complaint survey for CCR #2018007147 and CCR #2018007841 was conducted 6/12/18 through 6/13/18 at Heartland Health Care Center - North Sarasota, a skilled nursing facility in Sarasota, Florida, Heartland Health Care Center - North Sarasota is in compliance with Code of Federal Regulations (CFR) 42, Part 483, Requirements for Long-Term Care Facilities.

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

TITLE

06/29/2018

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

۵ħ

	I I IM- C Adminis					APPROVED			
Agency for Health Care Administra STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:  B. WING		(X3) DATE SURVEY COMPLETED  C 06/13/2018				
		85806							
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE					
HEARTLAND HEALTH CARE CENTER - NORTH SARA  3250 12TH ST SARASOTA, FL 34237									
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE			
N 000	INITIAL COMMENTS		N 000						
	#2018007147 and Co conducted 6/12/18 th Health Care Center - nursing facility (licens Florida.	nplaint survey for CCR R.#2018007841 was rough 61/31/8 at Hearland North Sarasota, a skilled e #12840961) in Sarasota, found at the time of the visit.							

AHCA Form 3020-0001 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

06/29/18 Electronically Signed