

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969703	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 11/01/2023
NAME OF PROVIDER OR SUPPLIER LIANA OF SARASOTA		STREET ADDRESS, CITY, STATE, ZIP CODE 2630 UNIVERSITY PARKWAY SARASOTA, FL 34243			
(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 A follow-up by desk review was conducted from 10/30/23 through 11/1/23 for Liana of Sarasota, an assisted living facility in Sarasota, Florida. The follow-up was in response to the relicensure, limited nursing services, health facility reporting system, generator, visitation monitoring and complaint survey completed on 9/14/23. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 10/14/23.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE