

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967880	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/04/2024
NAME OF PROVIDER OR SUPPLIER ALIVIYA ROSE MANOR LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 14180 AMERO LN SPRING HILL, FL 34609		
(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 000}		
A 000	Initial Comments An unannounced follow up to the re-licensure, extended congregate care, emergency power plan monitoring, generator assessment, and bed capacity increase monitoring survey was conducted by desk review on September 4, 2024 for Aliviya Rose Manor, LLC. Prior deficient practice was found corrected at the time of the review.	A 000		

AHCA Form 3020-0001

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

TITLE

(X8) DATE