

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 08/19/2025
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 An unannounced revisit survey was conducted on 8/18/25 through 8/19/25 at Liana of Sarasota. This was the follow up to the relicensure, limited nursing services, emergency power plan monitoring, health facility reporting system, and visitation form survey was conducted on 4/24/25. The provider had no deficiencies at the time of the visit..	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE