

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969329	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 04/23/2020
NAME OF PROVIDER OR SUPPLIER LIANA OF VENICE		STREET ADDRESS, CITY, STATE, ZIP CODE 2321 E VENICE AVE VENICE, FL 34292			
(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 4/22/20 through 4/23/20 for Liana of Venice, an assisted living facility in Venice, Florida. The follow-up was in response to the re-licensure, limited nursing services, and emergency power plan monitoring survey completed on 2/25/20. Based on the facility's supporting documentation, the deficiencies were corrected as of 4/23/20.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X6) DATE