

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963950	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 02/20/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BENEVA LAKES ASSISTED LIVING CENTER

**743 S. BENEVA ROAD
SARASOTA, FL 34232**

(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 4th revisit to a complaint survey was conducted on 2/20/23 at Beneva Lakes Assisted Living Center, an assisted living facility in Sarasota, Florida. This was a follow-up to the complaint survey completed/revisited on 6/29/21, 11/2/21, 3/9/22 and 9/20/22. The survey was completed in conjunction with a complaint investigation and a revisit survey. The previous deficiencies were found corrected and new deficiencies were identified in survey ID WK0R11.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE