

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 10/25/2024
NAME OF PROVIDER OR SUPPLIER ASPIRE AT BENEVA VILLAS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 An unannounced change of ownership, emergency power plan, health facility reporting system, visitation form, and complaint survey for #2023009143, #2023012341, #2023012762, #2023017079, and #2023017824 was conducted on 10/25/24, at Aspire at Beneva Villas, an assisted living facility in Sarasota, Florida. Complaint #2023009143 was not substantiated. Complaint #2023012341 was not substantiated. Complaint #2023012762 was not substantiated. Complaint #2023017079 was not substantiated. Complaint #2023017824 was not substantiated. There were no deficiencies found at the time of the survey.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE