

Agency for Health Care Administration

|                                                                    |                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                          |                          |                                                        |
|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963950</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/18/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ASPIRE AT BENEVA VILLAS</b> |                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>743 S. BENEVA ROAD<br/>SARASOTA, FL 34232</b>                                |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 000                                                              | <p><b>Initial Comments</b></p> <p>An unannounced complaint survey for # 2025001954 was conducted on 3/18/25 at Aspire at Beneva Villas, an assisted living facility in Sarasota, Florida.</p> <p>Complaint #2025001954 was substantiated without deficient practice</p> <p>There were no deficiencies identified at the time of the survey.</p> | A 000                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

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

TITLE

(X8) DATE