

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11953679	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/25/2025
NAME OF PROVIDER OR SUPPLIER SAVANNAH GRAND OF SARASOTA			STREET ADDRESS, CITY, STATE, ZIP CODE 7130 BENEVA ROAD SARASOTA, FL 34238		
(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 survey by desk review was conducted on 6/20/25 through 6/25/25 for Savannah Grand of Sarasota, an assisted living facility in Sarasota, Florida. The follow-up was in response to the relicensure, emergency power plan, health facility reporting system, visitation form, and complaint survey completed on 4/22/25. Based on the facility's plan of correction, and supporting documentation, the deficiencies were corrected as of 5/22/25 and no new deficiencies were identified at the time of the survey.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE