

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964518	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/21/2025
NAME OF PROVIDER OR SUPPLIER THE MEADOWS OF SARASOTA SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1809 18TH STREET SARASOTA, FL. 34234		
(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 revisit survey by desk review was conducted for The Meadows of Sarasota Senior Living from 8/15/25 through 8/21/25. This was a follow up to the relicensure, emergency power plan monitoring, health facility reporting system, visitation form and complaint survey completed on 3/20/25 and revisit completed on 6/26/25. Deficiencies were found to be corrected at the time of the survey.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE