

Agency for Health Care Administration

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964789</b>                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>03/23/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BROOKDALE BONITA SPRINGS</b> |                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>26850 SOUTH BAY DRIVE<br/>BONITA SPRINGS, FL 34134</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>Initial Comments</p> <p>A revisit survey was conducted 3/23/21 at Brookdale Bonita Springs, an assisted living facility in Bonita Springs, Florida.</p> <p>This was a follow-up to the complaint survey #2020008186 completed on 1/25/21.</p> <p>The previous deficiencies were corrected and no new deficiencies were found at the time of the visit.</p> | {A 000}                                                                                            |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

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

TITLE

(X6) DATE