

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964789	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/09/2022
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NAME OF PROVIDER OR SUPPLIER BROOKDALE BONITA SPRINGS	STREET ADDRESS, CITY, STATE, ZIP CODE 26850 SOUTH BAY DRIVE BONITA SPRINGS, FL 34134
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(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 re-licensure, limited nursing services and emergency power plan monitoring survey was conducted on 8/9/22 at Brookdale Bonita Springs, an assisted living facility in Bonita Springs, Florida. No deficiencies were found at the time of the visit.	A 000		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE