STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964789	11/24/2015
NAME OF PROVIDER OR SUPPLIER **BROOKDALE BONITA SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **26850 SOUTH BAY DRIVE** **BONITA SPRINGS, FL 34134**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced complaint survey for CCR# 2015009107 was conducted / / at Brookdale Bonita Springs, an assisted living facility in Bonita Springs, Florida.

The complaint contained 2 allegations, of which none were substantiated. There was an unrelated deficiency.

The following is description of the deficiency that was found at the time of the visit.

0167 Resident Contracts

Based on record review, and interview, the facility failed to have proper documentation designating the Power of Attorney (POA) for a family member for 2 (Residents #1 and #4) of 3 resident records reviewed.

The findings include:

1. Record review for Residents #1 and #4 had the residency agreement signed by a family member. Further record review revealed there was no POA documentation in the files to indicate the family member can sign on behalf of the resident.

2. On / / at 2:30 p.m., the Executive Director verified there was no documentation in the resident records after her review. She said she will get in touch with the families to produce the paperwork.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

_ _ _ _ _ _ _ _ _ _, 2015

Administrator
Brookdale Bonita Springs
26850 South Bay Drive
Bonita Springs, FL 34134

RE: CCR #2015009107

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than _ _ _ _ _ _ _ _ _ _, 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor(s). Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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