STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964789	02/09/2016
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 Limited Nursing Service survey was conducted at Brookdale Bonita Springs, an Assisted Living Facility in Bonita Springs, Florida.

No deficiencies were found in relation to the Limited Nursing Service survey. There is an unrelated deficiency.

The following is the deficiency.

0025 Resident Care - Supervision

Based on record review and interview, the facility failed to notify the physician or family member in regards to a change of resident condition for 1 (Residents #3) of 4 resident records reviewed.

The findings included:

On _/_ at 11:30 a.m., record review showed Resident #3 had an 8 pound weight loss 2015 - 2015 and a 16 pound weight gain 2015 - 2016. There was no documentation of family or physician being notified.

On _/_ at 11:53 a.m. during an interview the Health and Wellness Director said it doesn't make sense to her. She said the staff working on the floor get a list of who needs weighs and gives it to the nurse for review. It goes in the nutrition tracker and the program automatically the weight loss or weight gain and triggers the individual resident. She said she accepts responsibility for missing the weight.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative 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 , 2016.** 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. 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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