STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964789	06/14/2016
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 complaint survey, CCR #2016004875 was conducted on / / at Brookdale Bonita Springs, an Assisted Living Facility (license #9322), in Bonita Springs, Florida.

The complaint consisted of 1 allegation which was unsubstantiated.

There is one unrelated deficiency.

The following is a description of the deficiency.

0162 Records - Resident

Based on record review and staff interview, the facility failed to ensure documentation of the appointment of a POA (Power of Attorney) was found in the resident record for 1 (Resident #1) of 4 resident records reviewed.

The findings included:

The record for Resident #1 contained a contract for services signed by the resident's son with the designation POA ascribed. The resident's record only included documentation of the son as the health care surrogate. There was no power of attorney documentation in the file.

In an interview with the Business Office Manager on at 11:49 a.m., she confirmed there was no documentation of the appointment of a POA for Resident #1.

Class

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

RE: CCR #2016004875

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representatives of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 this deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiency. 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 deficiency 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 surveyors. 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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