

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964709	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/14/2020
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NAME OF PROVIDER OR SUPPLIER BROOKDALE BLUEWATER BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 1551 MERCHANTS WAY NICEVILLE, FL 32578
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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 On 4/14/20, a desk review revisit licensure survey was completed for the biennial standard survey with Limited Nursing Services, Comprehensive Emergency Management Plan, and Generator Assessment dated 12/30/2019 at Brookdale Bluewater Bay. Based on submitted evidence of correction and supporting documentation, deficiencies were found corrected.	{A 000}		

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

TITLE

(X6) DATE