Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11942866	A. BUILDING: _____ B. WING _____	09/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTYARDS ASSISTED LIVING (THE)	26455 RAMPART BLVD. PUNTA GORDA, FL 33983

(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 complaint survey for #2021006851, #2021008032, and #2021011917 was conducted 9/7/21 through 9/9/21 at The Courtyards Assisted Living, an assisted living facility in Punta Gorda, Florida. This survey was conducted in conjunction with a second revisit survey to a relicensure, emergency power plan monitoring, focused infection control, and complaint survey that was completed on 1/14/21. Complaint #2021006851 was substantiated at A030 and Z814. Complaint #2021008032 was substantiated at A025, A030 and Z814. Complaint #2021011917 was substantiated at A030 and Z814. Please refer to survey ZIMD13 for the uncorrect deficiencies A025, A030 and AZ815.	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE