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
	AL11968805	A. BUILDING: _____ B. WING _____	03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOUSE BONITA SPRINGS	11400 LONGFELLOW LN BONITA SPRINGS, FL 34135

(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 survey for complaints #2022010331, #2022012022, #2022014794, #2022015203, #2022015445, #2022015768, #2023000994 was conducted on 3/14 through 3/15/23 at American House Bonita Springs, an assisted living facility, in Bonita Springs, Florida. This survey was completed in conjunction with a relicensure with complaint revisit survey, which was recited. Complaint #2022010331 was substantiated without citation. Complaint #2022012022 was unsubstantiated. Complaint #2022014794 was substantiated without citation. Complaint #2022015203 was substantiated without citation. Complaint #2022015445 was substantiated without citation. Complaint #2022015768 was substantiated without citation. Complaint #2023000994 was unsubstantiated. No deficiencies identified at the time of the survey related to this survey.	A 000		