

Agency for Health Care Administration

|                                                                              |                                                                                                                                                                                                                                                       |                                                                                |                                                                                                                          |                          |                                                                    |
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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11968304</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>07/03/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>NEUROINTERNATIONAL HEALTHCARE LLC</b> |                                                                                                                                                                                                                                                       |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>7015 32ND AVE EAST<br/>BRADENTON, FL 34208</b>                               |                          |                                                                    |
| (X4) ID<br>PREFIX<br>TAG                                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                          | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                    |
| A 000                                                                        | Initial Comments<br><br>A complaint survey (Complaint #2024008555) in<br>conjunction with a generator monitoring survey<br>was conducted at Neurointernational Healthcare<br>on 07/03/2024. No deficiencies were identified at<br>the time of survey. | A 000                                                                          |                                                                                                                          |                          |                                                                    |

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE