

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER BROOKDALE FORT MYERS CYPRESS LAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 7460 LAKE BREEZE DRIVE FORT MYERS, FL 33919		
(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 #2024002617, #2023016390, & #2023009762 was conducted on 10/23/24 through 10/24/24, at Brookdale Fort Myers Cypress Lake, an assisted living facility in Fort Myers, Florida. Complaint #2024002617 was substantiated without deficient practice. Complaint #2023016390 was not substantiated. Complaint #2023009762 was not substantiated. There were no deficiencies found at the time of the survey.	A 000		

AHCA Form 3020-0001

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

TITLE

(X8) DATE