

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/07/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE COCONUT POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 8460 MURANO DEL LAGO DR 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 A follow-up survey by desk review was conducted on 1/2/25 through 1/7/25, for American House Coconut Point, an assisted living facility in Bonita Springs, Florida. The follow-up was in response to the relicensure, limited nursing services, emergency power plan monitoring, generator form, visitation form, and complaint survey completed on 9/17/24. Based on the facility's plan of correction, and supporting documentation, the deficiency was corrected as of 10/17/24 and no new deficiencies were identified.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE