

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968805	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/25/2025
NAME OF PROVIDER OR SUPPLIER AMERICAN HOUSE BONITA SPRINGS			STREET ADDRESS, CITY, STATE, ZIP CODE 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 A follow-up survey by desk review was conducted on 1/22/25 through 1/25/25 for American House Bonita Springs, an assisted living facility in Bonita Springs, Florida. The follow-up was in response to the complaint survey completed on 10/31/24. Based on the facility's plan of correction, and supporting documentation, the deficiencies were corrected as of 11/30/24 and no new deficiencies were identified.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE