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
	AL11968252	A. BUILDING: _____ B. WING _____	R 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS AT SHELL POINT RETIREMENT COMMUNIT	13901 SHELL POINT PLZ FORT MYERS, FL 33908

(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 4/25/25 through 4/29/25 for The Springs at Shell Point, an assisted living facility in Fort Myers, Florida. The follow-up was in response to the relicensure, extended congregate care, emergency power plan monitoring, health facility reporting system, visitation form, and complaint survey conducted on 3/4/25. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 4/4/25 and no new deficiencies were identified. .	A 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE