

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969477	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/28/2025
NAME OF PROVIDER OR SUPPLIER AMAVIDA AT LAKES PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 7669 CALISTOBLE LOOP 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 5/23/25 through 5/28/25 for Amavida at Lakes Park, an assisted living facility in Fort Myers, Florida. The follow-up was in response to the change of ownership, limited nursing services, emergency power plan monitoring, visitation form and complaint survey completed on 4/1/25. Based on the facility's plan of correction, and supporting documentation, the deficiencies were corrected as of 5/1/25 and no new deficiencies were identified.	{A 000}		

AHCA Form 3020-0001

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

TITLE

(X6) DATE