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 |
|---|---|---|---|
| | AL11964870 | A. BUILDING: _____ B. WING _____ | 06/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PACIFICA SENIOR LIVING FORT MYERS | 9461 HEALTHPARK CIRCLE 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<br><br>An unannounced emergency power plan monitoring, and complaint investigation #2025008197 was conducted on 6/18/25 through 6/19/25 at Pacifica Senior Living Fort Myers, an assisted living facility in Fort Myers, Florida. The survey was conducted in conjuction with a revisit survey.<br><br>Complaint #2025008197 was substantiated without citation.<br><br>The facility had no deficiencies at the time of the survey.<br>. | A 000 | | |

AHCA Form 3020-0001

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