

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911215	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER HARBOUR HEALTH ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 23013 WESTCHESTER BLVD PORT CHARLOTTE, FL 33980		
(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 An unannounced complaint investigation for #2024005232, #2024015228, & #2025003881 and an emergency power plan monitoring survey was conducted at Harbour Health Assisted Living on 8/13/25 through 8/14/25. Complaint # 2024005232 was not substantiated. Complaint # 2024015228 was substantiated without citation. Complaint # 2025003881 was not substantiated The facility had no deficiencies at the time of the survey. .	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE