

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11970200	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/06/2025
NAME OF PROVIDER OR SUPPLIER BRIDGEPOINTE ASSISTED LIVING FACILITY LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 113 NE 7 ST POMPANO BEACH, FL 33060		
(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 revisit to the Generator Monitoring survey was conducted by desk review on 10/06/2025 for Bridgepointe Assisted Living Facility LLC. The previously cited deficiencies were found corrected at the time of the survey.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE