

Agency for Health Care Administration

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|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11963725</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/15/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BELLA VITA</b> |                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1420 EAST VENICE AVENUE<br/>VENICE, FL 34292</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                 | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| A 000                                                 | <p><b>Initial Comments</b></p> <p>These are the results for Complaint survey CCR#2012008539 completed at Bella Vita, an Assisted Living Facility on 8/15/12.</p> <p>There were 2 allegations in this complaint which were not confirmed.</p> | A 000                                                                                        |                                                                                                                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

RGZE11

If continuation sheet 1 of 1

RICK SCOTT  
GOVERNOR



*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

August 30, 2012

Administrator  
Bella Vita  
1420 East Venice Avenue  
Venice, FL 34292

**Re: CCR #2012008539**

Dear Administrator:

This letter reports the findings of a complaint survey completed on August 15, 2012 by a representative of this office.

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, Form CMS-2567, and State (3020) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions, please contact this office at (239) 335-1315.

Sincerely,

A handwritten signature in black ink, appearing to read "Harold D. Williams", written over a horizontal line.

Harold D. Williams  
Field Office Manager

bw  
Enclosure

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Headquarters  
2727 Mahan Drive  
Tallahassee, FL 32308  
<http://ahca.myflorida.com>



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Fort Myers Field Office  
2295 Victoria Avenue, Room 340  
Fort Myers, FL 33901  
Phone (239) 335-1315; Fax (239) 338-2372