STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968805	05/17/2016
NAME OF PROVIDER OR SUPPLIER **AMERICAN HOUSE BONITA SPRINGS**	STREET ADDRESS, CITY, STATE, ZIP CODE **11400 LONGFELLOW LN** **BONITA SPRINGS, FL 34135**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Limited Nursing Services survey was conducted 5/17/16 at American House, an Assisted Living Facility in Bonita Springs, Florida.

No deficiencies were found at the time of the visit.

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

May 27, 2016

Administrator
American House Bonita Springs
11400 Longfellow Ln
Bonita Springs, FL 34135

Dear Administrator:

This letter reports findings of a state licensure survey that was conducted on May 17, 2016 by a representative of this office. Attached is the provider's copy of the State (5000-3547) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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 call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

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