DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105723	A. BUILDING _____ B. WING _____	C 10/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER FORT MYERS	**1600 MATTHEW DRIVE FORT MYERS, FL 33907**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey for CCR# 2017012291 was conducted on 10/25/17 at Heartland Healthcare Center, a skilled nursing facility in Fort Myers, Florida. The complaint contained 2 allegations, of which 1 allegation was unsubstantiated and 1 allegation is substantiated without citation. Heartland Healthcare Center was found to be in substantial compliance with Code of Federal Regulations (CFR) 42, Part 483, Requirements for Long-Term Care Facilities for this complaint investigation.	F 000		

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

Electronically Signed | 11/15/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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
	83610	A. BUILDING: _____ B. WING _____	C 10/25/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND HEALTH CARE CENTER FORT MYERS	1600 MATTHEW DRIVE FORT MYERS, FL 33907

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N 000	INITIAL COMMENTS An unannounced complaint survey for CCR# 2017012291 was conducted on 10/25/17 at Heartland Healthcare Center, a skilled nursing facility (license # 12060961) in Fort Myers, Florida. The complaint contained 2 allegations, of which 1 allegation was unsubstantiated and 1 allegation is substantiated without citation. No deficiencies were found at the time of the visit.	N 000		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/15/17