

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/22/2020
NAME OF PROVIDER OR SUPPLIER BEACH HOUSE NAPLES ASSISTED LIVING & MEMOF		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 AIRPORT PULLING RD S NAPLES, FL 34104			
(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 survey for #2020016247 and focused infection control visit was conducted on 12/22/20 at Beach House Naples Assisted Living & Memory Care, an assisted living facility in Naples, Florida. Complaint #2020016247 was unsubstantiated. No deficiencies were found at the time of the visit.	A 000			

AHCA Form 3020-0001

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

TITLE

(X6) DATE