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
	AL11969892	A. BUILDING: _____ B. WING _____	R 09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE RESERVE OF NAPLES CORP	3440 52 AVE NE NAPLES, FL 34120

(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 follow-up survey by desk review was conducted on 9/5/24 through 9/6/24, for Sunrise Reserve of Naples Corp, an assisted living facility in Naples, Florida. The follow-up was in response to the relicensure, limited mental health, emergency power plan, health facility reporting system, visitation form, and complaint survey conducted on 6/25/24. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 7/25/24 and no new deficiencies were identified. .	A 000		
{A 000}	Initial Comments	{A 000}		

AHCA Form 3020-0001

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