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
	AL11969678	A. BUILDING: _____ B. WING _____	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEAPPLE HOUSE AT SAPPHIRE LAKES, THE	7901 RADIO RD 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 relicensure, limited nursing services, emergency power plan, health facility reporting system, visitation form, and complaint survey for #2023017875, #2024003891, #2024005985, and #2024010282, was conducted on 11/13/24 through 11/15/24 at The Pineapple House at Sapphire Lakes, an assisted living facility in Naples, Florida. Complaint #2023017875 was not substantiated. Complaint #2024003891 was not substantiated. Compalint #2024005985 was substantiated without citation. Complaint #2024010282 was not substantiated. 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