

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965121	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 12/05/2024
NAME OF PROVIDER OR SUPPLIER THE COLLIER AT NAPLES			STREET ADDRESS, CITY, STATE, ZIP CODE 770 GOODLETTE ROAD, NORTH NAPLES, FL 34102		
(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 12/5/24 for The Collier at Naples, an assisted living facility in Naples, Florida. The follow-up was in response to the relicensure, emergency power plan monitoring, health facility reporting system, visitation form, and complaint survey for #2023016157, conducted on 9/11/24. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 12/5/24 and no new deficiencies were identified.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE