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
	AL11969878	A. BUILDING: _____ B. WING _____	R 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FAIRWAYS AT NAPLES	3053 AIRPORT PULLING RD NAPLES, FL 34105

(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 12/6/24 through 12/11/24, for The Fiarways at Naples, an assisted living facility in Naples, Florida. The follow-up was in response to the relicensure, limited nursing services, emergency power plan, health facility reporting system, visitation form, and complaint survey completed on 6/18/24 and the first revisit survey completed on 9/6/24. This survey was completed in conjunction with a post storm assessment revisit survey. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 12/10/24, and no new deficiencies were identified. .	{A 000}		

AHCA Form 3020-0001

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