

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11965374	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/16/2025
NAME OF PROVIDER OR SUPPLIER THE ELITE ALF AT NAPLES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1155 ENCORE WAY NAPLES, FL 34110			
(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 revisit survey was conducted on 1/16/25 at The Elite ALF at Naples in Naples LLC, Florida. This was a follow-up to the relicensure, limited nursing services, emergency power plan monitoring, health facility reporting system, generator form, visitation form, and complaint survey for #2023016854, #2023017002, #2024002423, and #2023010309 completed on 6/3/24 through 6/4/24. The previous deficiencies were found to be corrected and no new deficiencies were identified at the time of the visit.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE