

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11969600	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/07/2025
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NAME OF PROVIDER OR SUPPLIER LA SHEKINAH ASSISTANCE LIVING LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1732 45 TERR SW NAPLES, FL 34116
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(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 mental health, emergency power plan monitoring, and visitation form survey was conducted on 1/7/25 at La Shekinah Assistance Living LLC, an assisted living facility in Naples, Florida. 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

(X8) DATE