

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11968979	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 02/19/2025
NAME OF PROVIDER OR SUPPLIER BEACH HOUSE NAPLES ASSISTED LIVING & MEMOF			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 AIRPORT PULLING RD S 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 A follow-up by desk review was conducted 2/14/25 through 2/19/25 for Beach House Naples Assisted Living & Memory Care, an assisted living facility in Naples, Florida. The follow-up was in response to the relicensure, limited nursing services, emergency power plan monitoring, health facility reporting system, visitation form and complaint survey completed on 12/17/24 Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 2/18/25 and no new deficiencies were identified.	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE