

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 12/22/2025
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 A revisit by desk review to the relicensure, limited nursing services, emergency power plan monitoring, health facility reporting system and complaint investigation survey was conducted for The Elite ALF at Naples Llc on 12/18/25 through 12/22/25. Deficiencies were found to be corrected at the time of the survey	{A 000}			

AHCA Form 3020-0001

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

TITLE

(X8) DATE