

Agency for Health Care Administration

|                                                            |                                                                                                                                                                                                                            |                                                                                |                                                                                                                          |                          |                                                        |
|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION        |                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11932376</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>06/17/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ARISTOCRAT, THE</b> |                                                                                                                                                                                                                            |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>10949 PARNU STREET<br/>NAPLES, FL 34109</b>                                  |                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                               | ID<br>PREFIX<br>TAG                                                            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                        |
| A 000                                                      | <p>Initial Comments</p> <p>A Complaint Survey, CCR# 2013003017 was conducted at The Aristocrat, an Assisted Living Facility (ALF), on 6/17/13.</p> <p>The allegation was not substantiated and there are no citations.</p> | A 000                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

RFR11

If continuation sheet 1 of 1



RICK SCOTT  
GOVERNOR

ELIZABETH DUDEK  
SECRETARY

June 20, 2013

Administrator  
Aristocrat, The  
10949 Parnu Street  
Naples, FL 34109

**Re: CCR #2013003017**

Dear Administrator:

This letter reports the findings of a complaint survey completed on June 17, 2013 by representative(s) of this office.

Attached is the provider's copy of the Statement of Deficiencies and Plan of Correction, State (3020) Form, indicating no deficiencies were identified during this survey. **You will not receive a copy of this report in the mail; you will only receive this faxed copy.**

The *Quality Assurance Questionnaire* has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at <http://ahca.myflorida.com/Publications/Forms.shtml> as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under **Health Facilities and Providers** on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the surveyor. Should you have any questions, please contact this office at (239) 335-1315.

Sincerely,

Harold D. Williams  
Field Office Manager

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Enclosure: State Form

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Headquarters  
2727 Mahan Drive  
Tallahassee, FL 32308  
<http://ahca.myflorida.com>



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Fort Myers Field Office  
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