

Agency for Health Care Administration

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|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION           |                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11969489</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/05/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SEASCAPE AT NAPLES</b> |                                                                                                                                                                                                                                    |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3490 THRIVE DR<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><b>Initial Comments</b></p> <p>An unannounced monitoring visit was conducted on 8/5/2024 at Seascape at Naples, an assisted Living facility in Naples, Florida.</p> <p>No deficiencies were found at the time of the visit.</p> | A 000                                                                          |                                                                                                                          |                          |                                                        |

AHCA Form 3020-0001

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

TITLE

(X6) DATE