

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964914	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 02/18/2025
NAME OF PROVIDER OR SUPPLIER CARLISLE NAPLES		STREET ADDRESS, CITY, STATE, ZIP CODE 6945 CARLISLE COURT NAPLES, FL 34109			
(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 2/18/25 for Carlisle Naples an assisted living facility in Naples, Florida. The follow-up was in response to the extended congregate care, emergency power plan monitoring, visitation form, and complaint survey completed on 12/3/24. Based on the facility's plan of correction and supporting documentation, the deficiencies were corrected as of 1/3/25 and no new deficiencies were identified.	A 000			

AHCA Form 3020-0001

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

TITLE

(X8) DATE