STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964914	04/05/2016
NAME OF PROVIDER OR SUPPLIER **CARLISLE NAPLES**	STREET ADDRESS, CITY, STATE, ZIP CODE **6945 CARLISLE COURT** **NAPLES, FL 34109**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Extended Congregate Care (ECC) survey was conducted on at Carlisle Naples, an Assisted Living Facility in Naples, Florida.

The following is description of the deficiency.

0152 Physical Plant - Safe Living Environ/Other

Based on observation and interview, the facility failed to maintain an environment for residents free from hazards.

The findings included:

1. During a tour of the facility on surveyor observed the following:

- slats missing from window and cover over electric wall outlet missing;

Laundry 3rd floor - floor dirty;

- curtain covered with large amount of black substance and multiple stains noted on rug;

- stain noted on , caulking around vanity in and rust colored;

- stained;

- door frame had large gouge marks, large piece of plaster missing from wall, live worm noted on shower floor, very dusty, and carpet had stains;

- carpet had stains;

- large hole noted in hallway wall;

2. During interview with Assisted Living Director on at 11:00 a.m., she reported the housekeepers clean the resident once a week.

Class III

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SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Carlisle Naples
6945 Carlisle Court
Naples, FL 34109

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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 call this office at (239) 335-1315.

Sincerely,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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