

AGENCY FOR HEALTH CARE
ADMINISTRATION

PRINTED: 08/17/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11964914	(X3) DATE SURVEY COMPLETED R 08/11/2016
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 revisit survey was conducted on 8/11/16 at Carlisle Naples, an Assisted Living Facility, (license #9408) in Naples, Florida. This was a follow-up to the follow-up survey completed on 6/15/16.

The previous deficiency was found corrected and no new deficiencies were identified.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11964914	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/11/2016
NAME OF FACILITY CARLISLE NAPLES	STREET ADDRESS, CITY, STATE, ZIP CODE 6945 CARLISLE COURT NAPLES, FL 34109	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0152	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.023(3) FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/11/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) <i>[Signature]</i>	DATE 8-17-16	SIGNATURE OF SURVEYOR <i>[Signature]</i> Robin Heilmann, RNS	DATE 8-17-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/5/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

August 17, 2016

Administrator
Carlisle Naples
6945 Carlisle Court
Naples, FL 34109

Dear Administrator:

This letter reports the findings of a state monitoring survey revisit conducted on August 11, 2016 by a representative of this office.

Attached is the provider's copy of the State Form, which indicates the previously cited deficiency was found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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,

A handwritten signature in black ink, appearing to read "Jon Seehawer".

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form and Revisit Report

DT9D

