

Agency for Health Care Administration

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                          |  |                                                              |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                  |                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11965374</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R<br/>09/05/2012</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>JUNIPER VILLAGE AT NAPLES</b> |                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>1155 ENCORE WAY<br/>NAPLES, FL 34110</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>This is the Biennial and Limited Nursing Services survey revisit completed on 9/05/12 at Juniper Village at Naples, an Assisted Living Facility. The facility census on the day of survey was 55.</p> <p>All previous citations have been substantially improved or corrected.</p> <p>No deficiencies were cited relevant to the survey during this visit.</p> | {A 000}                                                                        |                                                                                                                          |  |                                                              |

AHCA Form 3020-0001

TITLE

(X5) DATE

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

STATE FORM

0000

QYHY12

If continuation sheet 1 of 1

9/10/2012

## State Form: Revisit Report

|                                                                       |                                                      |                                  |
|-----------------------------------------------------------------------|------------------------------------------------------|----------------------------------|
| (Y1) Provider / Supplier / CLIA / Identification Number<br>AL11965374 | (Y2) Multiple Construction<br>A. Building<br>B. Wing | (Y3) Date of Revisit<br>9/5/2012 |
|-----------------------------------------------------------------------|------------------------------------------------------|----------------------------------|

Name of Facility

JUNIPER VILLAGE AT NAPLES

Street Address, City, State, Zip Code

1155 ENCORE WAY  
NAPLES, FL 34110

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).

| (Y4) Item                                                              | (Y5) Date                                 | (Y4) Item                                                                      | (Y5) Date                                 | (Y4) Item                                    | (Y5) Date            |
|------------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------|
| ID Prefix <u>A0025</u><br>Reg. # <u>58A-5.0182(1) FAC</u><br>LSC _____ | Correction Completed<br><u>09/05/2012</u> | ID Prefix <u>A0030</u><br>Reg. # <u>58A-5.0182(6) FAC: 429.28</u><br>LSC _____ | Correction Completed<br><u>09/05/2012</u> | ID Prefix _____<br>Reg. # _____<br>LSC _____ | Correction Completed |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                           | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                                   | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____ | Correction Completed |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                           | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                                   | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____ | Correction Completed |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                           | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                                   | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____ | Correction Completed |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                           | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                                   | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____ | Correction Completed |
| ID Prefix _____<br>Reg. # _____<br>LSC _____                           | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____                                   | Correction Completed                      | ID Prefix _____<br>Reg. # _____<br>LSC _____ | Correction Completed |

|                    |                   |                |                                          |                |
|--------------------|-------------------|----------------|------------------------------------------|----------------|
| Reviewed By _____  | Reviewed By _____ | Date: _____    | Signature of Surveyor: <i>Mary Pinto</i> | Date: _____    |
| State Agency _____ | <i>HFES</i>       | <i>9-10-12</i> | <i>MARY PINTO, PHC</i>                   | <i>9-10-12</i> |
| Reviewed By _____  | Reviewed By _____ | Date: _____    | Signature of Surveyor: _____             | Date: _____    |
| CMS RO _____       |                   |                |                                          |                |

Followup to Survey Completed on:

7/18/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?

YES NO



RICK SCOTT  
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK  
SECRETARY

September 11, 2012

Administrator  
Juniper Village At Naples  
1155 Encore Way  
Naples, FL 34110

Dear Administrator:

This letter reports the findings of a Biennial survey revisit conducted on September 5, 2012 by a representative of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were 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,

Harold D. Williams  
Field Office Manager

bw  
Enclosure

