Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11965374	A. BUILDING _____ B. WING _____	12/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUNIPER VILLAGE AT NAPLES	1155 ENCORE WAY NAPLES, FL 34110

(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 This is an unannounced Limited Nursing Services (LNS) monitoring survey, completed on 12/10/12 at Juniper Village at Naples, an Assisted Living Facility, located in Naples, Florida. The facility census on the survey date is 63. There are 3 residents receiving LNS services. There were no related deficiencies identified at the time of the survey.	A 000		

REFERRAL TRACKING FORM

Must be completed for every ASPEN Event ID and submitted to field office

Facility	City	Facility Type	Facility Administrator & Fax Number
Juniper Village at Naples	Naples, FL.	ALF	ERIN Sakmar, Executive Director; Fax # 239-593-8603

Event ID#	Survey Date(s)	Survey Type/CCR#(s)
ULJP11	12/10/2012	LNS Monitoring Survey

Surveyor(s) Making Referral(s)

Carol Herbert, RNS #25891

Referral(s) (see below)	Date	Person and Issue
N/A		

1. DOH-MQA	2. DOH-Other	3. Abuse Hotline	4. DFS Fraud Unit
5. County Code Enforcement	6. Attorney General	7. Law Enforcement	8. Fire Marshall
9. Medicaid Fraud Control	10. LTCOC	11. Joint Commission	12. Medicare
13. Medicaid Program Integrity*	14. APD	15. Local Zoning	16. State Attorney
17. CARES Unit			

**Choose this before Medicaid Fraud Control*

Comments *(If referral, note who, what, when, where, how, why)*

Instructions

1. Type in the fields, the text will wrap around.

2. This form is required for every Event ID, and if survey covers multiple complaints, you must identify referral status for each.

3. If no referrals are made, indicate as N/A.

4. The pink forms used previously for referrals to DOH-MQA are no longer available; the referral matrix has a link. If link is used from the referral matrix, please print a screen shot of the referral (if able) to include with the survey paperwork.

5. Comments should be as detailed as possible; if call made, give number, date, time, who you spoke to, etc. Provide confirmation number if one is obtained.

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

December 18, 2012

Administrator
Juniper Village at Naples
1155 Encore Way
Naples, Florida 34110

Dear Administrator:

This letter reports findings of a Limited Nursing Services survey that was conducted on December 10, 2012 by representative(s) of this office. Attached is the provider's copy of the State (3020) Form, which indicates there were no discernible deficiencies noted on the date of the survey.

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(s). Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

HW:ss
Enclosure: State Form

65FO

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Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue, Room 340
Fort Myers, FL 33901
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