

Agency for Health Care Administration

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|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>AL11964677</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/02/2013</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ORCHID TERRACE</b> |                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>111 MOORINGS PARK DRIVE<br/>NAPLES, FL 34105</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><b>Initial Comments</b></p> <p>This is an unannounced Extended Congregate Care (ECC) survey, completed on 4/2/13 at Orchid Terrace at the Moorings Assisted Living Facility (ALF), located in Naples, FL.</p> <p>The census during the survey is 65 residents, with 36 residents receiving ECC services.</p> <p>There were no deficiencies identified during the survey.</p> | A 000                                                                          |                                                                                                                          |  |                                                        |

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

5899

14BV11

If continuation sheet 1 of 1

RICK SCOTT  
GOVERNOR



ELIZABETH DUDEK  
SECRETARY

April 9, 2013

Administrator  
Orchid Terrace  
111 Moorings Park Drive  
Naples, FL 34105

Dear Administrator:

This letter reports findings of an Extended Congregate Care (ECC) survey that was conducted on April 2, 2013 by a representative 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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams  
Field Office Manager

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Enclosure: State Form

