STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953368	06/09/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Harbor Memory Care Of North Collier	101 Cypress Way East Naples, FL 34110	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - E205 - 58a-5.030(6) Fac - Ecc - Health Assessment S-S= D

Specific Tag Findings:
These are the results of an unannounced Extended Congregate Care (ECC) survey conducted on . at HarborChase North Collier, an Assisted Living Facility (ALF) located in Naples, FL.

The following is a description of non-compliance:

E205-ECC - Health Assessment 58A-5.030(6) FAC
Based on record review and interview the facility failed to 1 (Resident #2) of 2 residents reviewed for Extended Congregate Care (ECC) services had a new health assessment at least annually.

The findings include:

1. Record review on . at 11:00 a.m. shows Resident #2 is receiving ECC services. Resident #2 has a physician order dated . for . at 2 liters per minute as needed for . The record shows the most current Health Assessment was completed on .

2. This resident stated during an interview on . at 10:50 a.m. that she is unable to manager her . independently.

3. The Director of Resident Care was interviewed on . at 11:00 a.m. She stated she, "Is aware the Health Assessments must be completed annually and is working on them."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2014

Administrator
Harbor Memory Care Of North Collier
101 Cypress Way East
Naples, FL 34110

Dear Administrator:

This letter reports the findings of an Extended Congregate Care (ECC) survey that was conducted on , 2014 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. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your 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

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