STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953368	**01/07/2015**
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)		

Revisit Corrected Tag:
E206-Ecc - Service Plans-01/07/2015

Revisit New Tags:
E207-Ecc - Services-58a-5.030(8) Fac

An unannounced follow-up survey was conducted on 1/7/15 at Harbor Memory Care of Naples, an Assisted Living Facility in Naples, Florida.

The following is a description of the deficient practice.

E207-ECC - Services 58A-5.030(8) FAC

Based on record review and interview the facility failed to have a nursing assessment done at least monthly, or more frequently if required by the resident's service plan, for 2 (Residents #1 and #2) out of 2 records reviewed.

The findings include:

1. Review of Resident #1's file revealed that there was no monthly assessment signed by a Registered Nurse on . . . . . and . . . . . and there was no monthly assessment done for . 2014.

2. Review of Resident #2's file revealed that there was no monthly assessment signed by a Registered Nurse on . . . . . and . . . . .

3. During an interview on . . . . at 5:25 p.m. Staff B said, "I usually send an E-mail to Staff C for her to review the assessment note and sign. She reviews the assessment and signs off on it."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2015

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

Dear Administrator:

This letter reports the findings of a state licensure survey revisit that was conducted on 7, 2015 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficieny that was identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct this deficiency 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 deficiency 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 offide at 239-335-1315.

Sincerely,

Jon Seehawer, RN
Acting Field Office Managr

JS:sp
Enclosure

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