STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11966171	08/17/2015
NAME OF PROVIDER OR SUPPLIER **BARRINGTON TERRACE OF NAPLES**	STREET ADDRESS, CITY, STATE, ZIP CODE **5175 TAMIAMI TRAIL EAST** **NAPLES, FL 34113**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced Extended Congregate Care (ECC) survey was conducted on / at Barrington Terrace, an Assisted Living Facility (ALF) in Naples, Florida.

The following is description of the deficiency found at the time of the visit.

E208 ECC - Records

Based on record review and interview, the facility failed to ensure that monthly nursing assessments were completed with the oversite of a Registered Nurse (RN) for 2 (Resident #1 and #2) of 2 residents reviewed for Extended Congregate Care services.

The findings included:

1. Record review on / / of record for Resident #1 revealed monthly nursing assessment dated / and , lacked the signature of a RN.

2. Record for Resident #2 revealed monthly nursing assessment documented for / lacked the signature of a RN.

3. During an interview on at 11:45 a.m., the Resident Care Director stated, "I thought it was okay to have the Executive Director sign it, we were mistaken. Our regional director was just here and she saw them but did not sign."

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2015

Administrator
Barrington Terrace Of Naples
5175 Tamiami Trail East
Naples, FL 34113

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on 2015 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. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2015.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

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,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

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