STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953368	10/20/2015
NAME OF PROVIDER OR SUPPLIER **HARBORCHASE OF NORTH COLLIER**	STREET ADDRESS, CITY, STATE, ZIP CODE **101 CYPRESS WAY EAST** **NAPLES, FL 34110**	

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

0000 Initial Comments

An unannounced Complaint Survey, CCR #2015011047 was conducted on through at Harborchase North Collier, an assisted living facility in Naples, Florida.

The complaint contained 3 allegations, of which 1 was substantiated with citation, one was substantiated without citation, and one was unsubstantiated.

The following is description of the deficiency.

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, the facility failed to honor resident's rights for a safe, clean, and decent living environment for 3 of 5 visited.

The findings included:

During the initial tour of the facility with the Director of Resident Care and another surveyor 3 (105, 303, and 410) of 5 observed were found to have scrapes, scuffs and/or red and brown residue on the walls of resident .

During an interview on Resident #1's family indicated Resident #1's not been cleaned since .

An interview with the Maintenance Director on revealed all are supposed to be cleaned weekly.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

[redacted], 2015

Administrator
Harborchase Of North Collier
101 Cypress Way East
Naples, FL 34110

RE: CCR #2015011047

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on [redacted], 2015 by representatives 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 [redacted], 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 surveyors. 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

XG90

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