STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911215	03/02/2016
NAME OF PROVIDER OR SUPPLIER **HARBOUR TERRACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **23013 WESTCHESTER BLVD** **PORT CHARLOTTE, FL 33980**	

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

0000 Initial Comments

An unannounced Complaint survey for, CCR #2015013352 and CCR #2015012965 was conducted on at Harbour Terrace, an Assisted Living Facility in Port Charlotte, Florida.

Complaint CCR #2015013352 had two allegations which were not substantiated with no citations.

Complaint CCR #2015012965 had one allegation which was substantiated with citation A0167.

The following is a description of the deficiency.

0167 Resident Contracts

Based on 2 of 3 resident closed records reviewed, billing reviewed, contract review, facility record review, and staff interviews, the facility failed to provide Resident #1 with a refund within 45 days of discharge. The facility also billed Resident #2 for charges he was not using.

The findings included:

1. A review of the facility's admission and discharge log showed Resident #1 was discharged from the facility on / . A review of Resident #1's contract dated showed he will pay $3,000.00 each month. A review of Resident #1's final billing showed an outstanding balance of $49.16.

An interview was conducted with the facility accountant on / at 11:30 a.m. He reviewed this bill and confirmed the facility continued to bill the $3,000.00 for the entire month of 2016.

An interview was conducted with the Director of Health and Wellness at 11:30 a.m. on / . She stated Resident #1's belongings were cleared from the / / . She confirmed once the cleared of his belongings the facility could rent out the another resident. Resident #1's bill should show an adjustment of the $3,000.00 for the use of the apartment from / / through / . Resident #1 did not use the apartment from / / through / . Resident #1 should have received a refund of $918.54 by . The accountant agreed Resident #1 should have received a refund from the facility within the 45 days of his discharge and it was not done.

2. An interview was conducted the Director of Health and Wellness at 12:00 p.m. on / . She stated Resident #2 left the facility on / / . However, the guardian requested to hold his . The plan is for him to return to the facility. The facility continues to bill the guardian every month for the she pays it.

AGENCY FOR HEALTH CARE ADMINISTRATION

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11911215	**03/02/2016**
NAME OF PROVIDER OR SUPPLIER **HARBOUR TERRACE**	STREET ADDRESS, CITY, STATE, ZIP CODE **23013 WESTCHESTER BLVD PORT CHARLOTTE, FL 33980**	

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

An interview was conducted with the facility accountant at 12:00 p.m. on . He confirmed he continues to bill Resident #2's guardian for his . A review of Resident #2's billing since showed the basic monthly rate and a "Personal Service Rate for $150.00 each month. A review of Resident #2's contract showed the $150.00 charge is for "Medication Assistance Package." Further review of this contract showed on page 10 if the resident's "absence extends beyond 14 days a reduction in fees other than the Base Monthly Fee will be considered by Harbour Terrace based on circumstances."

Interviews were conducted with the facility accountant and the Director of Health and Wellness at 12:25 p.m. on . They both confirmed Resident #2 should not have been charged with the $150.00 per month since he left the facility in 2015.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
Harbour Terrace
23013 Westchester Blvd
Port Charlotte, FL 33980

RE: CCR #2015012965 and CCR #2015013352

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiency 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. **Please attach a summary of your corrective action for this deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiency. Submit summary and documents to the Field Office no later than , 2016.** 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

sh
Enclosure: State Form

XG90

Fort Myers Field Office
2295 Victoria Avenue, [illegible]
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com