STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953368	05/04/2016
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 Extended Congregate Care monitoring survey was conducted on at Harbor Chase of North Collier, an Assisted Living Facility in Naples, Florida.

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

Z814 Background Screening Clearinghouse

Based on record review and interview, the facility failed to register the current employment status of all employees with the clearinghouse and maintain the employment status of employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days.

The findings included:

1. Review of employee records revealed Staff A was hired on ; Staff B was hired on / ; and Staff C was hired on / . Staffs A, B and C were not listed on the facility's employee roster on the background screening website. Review of the background screening clearinghouse employee roster for the facility found 21 employees listed. None of those 21 employees listed were current employees, as compared to the employee list provided by the facility.

2. On at 4:00 p.m., the Administrator confirmed their clearinghouse employee roster was not up to date. She said she did not know they had to submit the employee names to the roster and keep it updated.

Unclassified

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

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

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) 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 , 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(s). Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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