AGENCY FOR HEALTH CARE ADMINISTRATION

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 Complaint survey CCR #2016003911 was conducted on at Harborchase of North Collier, an assisted living facility in Naples, Florida.

There was 1 allegation which was substantiated at the time of the visit.

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

0025 Resident Care - Supervision

Based on record review and interview, the facility failed to maintain a written record, updated as needed, of significant changes for 1 (Resident #1) of 3 residents reviewed.

The findings include:

1. Review of resident records document Resident #1 was re-admitted to the facility on after hospitalization for a . Nursing progress notes dated between and discharge document Resident #1 had wounds to both heels that were being cared for by a home health company. There was no documentation of description, staging or size of the wounds available in the resident's file.

2. On at 4:00 p.m., the DON said the home health company was treating the wounds and kept documentation of that. She could not provide any documentation of description, staging, or size of the wounds.

On at 4:38 p.m., the Administrator confirmed the facility was not providing any treatments for the wounds and does not have any documentation from the home health company regarding the wounds on site. She said she will have to call the home health company for more information.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

I, 2016

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

RE: CCR #2016003911

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,

Jon Seehawer, R.N.
Field Office Manager

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Enclosure: State Form

XG90

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