

**AGENCY FOR HEALTH CARE
ADMINISTRATION**

PRINTED: 06/22/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911215	(X3) DATE SURVEY COMPLETED R
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 revisit to complaint survey was conducted on _____ at Harbour Terrace, an Assisted Living Facility (license #5075) in Port Charlotte, Florida. This is a follow up to the complaint survey completed on _____.
The previous deficiency was found to be corrected. The following is a new deficiency.

0162 Records - Resident

Based on record review and staff interview, the facility failed to ensure documentation of the appointment of a POA (Power of Attorney) was found in the resident record for 1 (Resident #1) of 20 resident records reviewed.

The findings included:

The record for Resident #1 contained a contract for services signed by the resident's son with the designation POA ascribed. The resident's record did not include documentation of the appointment of a health care surrogate, health care proxy, guardian, or the existence of a POA.

In an interview with the Director of Finance on _____ at 12:38 p.m., he confirmed there was no documentation of the appointment of a POA for Resident# 1.

Class _____

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER AL11911215	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT Y2 Y3
NAME OF FACILITY HARBOUR TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 23013 WESTCHESTER BLVD PORT CHARLOTTE, FL 33980	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0167	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 58A-5.025 FAC	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) <i>WWS</i>	DATE 6-22-16	SIGNATURE OF SURVEYOR <i>Wendy Snyder, RNC</i>	DATE 6-22-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

June 15, 2016

Administrator
Harbour Terrace
23013 Westchester Blvd
Port Charlotte, FL 33980

Dear Administrator:

This letter reports the findings of a State Licensure Revisit Survey conducted on June 15, 2016 by representatives of this office.

Attached are the provider's copy of the State (5000-3547) Form and Revisit Report which reference the corrected deficiency and the new deficiency identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **All deficiencies shall be corrected no later than June 22, 2016. 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 the identified deficiency. Submit summary and documents to the Field Office no later than June 22, 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 deficiency 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 and Revisit Report

YOSF

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