STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953368	R 08/09/2016
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 revisit survey was conducted on at Harborchase North Collier, an Assisted Living Facility, (license #8546), in Naples, Florida. This was a follow-up to the complaint survey, CCR #2016005741 completed on /

One of the previous deficiencies was found corrected, one was not and one new deficiency was identified.

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

0052 Medication - Assistance with Self-Admin

Based on observation and staff interview, Staff E failed to assist Resident #13 with self-administration of medications, as defined by Florida Statute 429.256 3 (c).

The findings included:

Florida Statute 429.256 3 (c) states, "Assistance with Self-Administration of Medications includes placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth."

On / at 11:05 a.m., Staff E was observed assisting Resident #13 with self-administration of medication. Staff E was observed placing a spoonful of applesauce with medications mixed on it, into Resident #13's mouth, with no assistance from Resident #13.

In an interview with Staff E, she stated, "I know they're supposed to help."

Class III

0054 Medication - Records

Based on record review and staff interview, facility staff failed to update the Medication Observation Record (MOR) each time the medication was offered or administered for 3 (Residents #13, #16, and #17) of all current residents' MORs reviewed.

The findings included:

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

1. On , a review of all current residents' MORs revealed the following:

There was no signature or explanation on the back of Resident #13's MOR for the at 10:00 p.m. dose of 0.25 mg.

On through , the 8:00 p.m. dose of Atarax 50 mg. was initialed and the initials were circled on Resident #17's MOR, but no explanation was written on the back of the MOR.

On and , there were no initials on Resident #16's MOR for the 8:00 p.m. dose of , but there were explanations written on the back of the MOR as to why it was not given.

2. In an interview with the Executive Director on at 11:45 a.m. she stated, "We will do an in-service with all the Med Techs, and will have pharmacy come and give them one too."

Class III

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
AL11953368	A. Building B. Wing	

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORCHASE OF NORTH COLLIER	101 CYPRESS WAY EAST NAPLES, FL 34110

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 A0056 Reg. # 58A-5.0185(7) FAC LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) DW	DATE 8-16-16	SIGNATURE OF SURVEYOR [signature] for: Robin Heimann, RNS	DATE 8-16-16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: 55TB12

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 revisit survey conducted on , 2016 by a representative of this office. Enclosed is the provider's copy of the Statement of Deficiencies (State Form 5000-3547), which references the uncorrected deficiencies and/or new deficiencies 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 , 2016.**

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

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Enclosure: State Form and Revisit Report

BBT7

Fort Myers Field Office
2295 Victoria Avenue, Room 340
Fort Myers, FL 33901
Phone:(239) 335-1315; Fax:(239) 338-2372
AHCA.MyFlorida.com

Facebook.com/ACHAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida