

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11963817	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/18/2012
NAME OF PROVIDER OR SUPPLIER TUSCANY VILLA OF NAPLES			STREET ADDRESS, CITY, STATE, ZIP CODE 8901 TAMiami TRAIL NAPLES, FL 34113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{A 000}	Initial Comments This is an unannounced follow up to a Limited Nursing Services survey completed on 12/18/12, at Tuscany Villa of Naples, an Assisted Living Facility. The facility census at the time of the survey was 114 residents with 18 residents receiving LNS. The previously cited deficiency was cleared and there were no other deficiencies noted during this survey.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6099

HB7112

If continuation sheet 1 of 1

12/21/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11963817	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/18/2012
Name of Facility TUSCANY VILLA OF NAPLES	Street Address, City, State, Zip Code 8901 TAMiami TRAIL NAPLES, FL 34113	

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>A0055</u> Reg. # <u>58A-5.0185(6) FAC</u> LSC _____	Correction Completed 11/18/2012	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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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	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
Reviewed By _____	Reviewed By <u>Wendy HFE</u>	Date: <u>12-21-12</u>	Signature of Surveyor: <u>Wendy HFE for: Joyce HFE, RNS</u>	Date: <u>12-21-12</u>	
State Agency _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____	
CMS RO _____					
Followup to Survey Completed on: 10/11/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO			



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

December 21, 2012

Administrator
Tuscany Villa of Naples
8901 Tamiami Trail
Naples, Florida 34113

Dear Administrator:

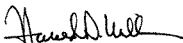
This letter reports the findings of a Limited Nursing Services survey revisit conducted on December 18, 2012 by representative(s) of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiency was found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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,



Harold D. Williams
Field Office Manager

HW:ss
Enclosures: State Form and Revisit Report

J5XD

