Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11911459	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT LAKE POINTE W	3270 LAKE POINTE BLVD SARASOTA, FL 34231

(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 These are the results for Complaint survey CCR# 2012004323 conducted on at The Fountains at Lake Point Woods, an Assisted Living Facility. There were 2 allegations in this complaint of which one was substantiated.	A 000		
A 028	58A-5.0182(4) FAC Resident Care - Activities of Daily Living (4) ACTIVITIES OF DAILY LIVING. Facilities shall offer supervision of or assistance with activities of daily living as needed by each resident. Residents shall be encouraged to be as independent as possible in performing ADLs. This Statute or Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure it offered supervision of or assistance with activities of daily living (ADLs) as needed by each resident for 3 (Residents #1, #2, and #3) of 3 residents samples as well as for 6 random residents. The findings include: 1. Review of Resident #1's "Resident Monthly Assignments" for 2012 on revealed the following: Bathing- Mon, Wed, Fri. ..... There was no documentation of a shower on Friday, ; Monday, ; Wednesday, ... Assisi/Adaptive Devices 1x(s) a day observe/provide assistive/adaptive	A 028		

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A 028	Continued From page 1 device. Remind to use. There was no documentation for 6/1, 6/2, 6/9, , , , or Endurance/mobility 4x(s) a day. Provide rest areas to/from meals/activities. There was no documentation for 6/1-a.m., 6/2-a.m. & p.m., 6/6-p.m., 6/8-p.m., 6/9-a.m., & p.m., or 2. Review of Resident #2's "Resident Monthly Assignments" for 2012 on revealed the following: Bathing- Mon, Wed, Fri. There was no documentation of shower for and Hearing-3x(s) a day. Support hearing needs. There was no documentation for 30 of 60 opportunities. Joint limitations 2x(s) a day. There was no documentations on 6/1, 6/2, 6/3, 6/4, 6/5, 6/7 through , , or through Oral medications. There was no documentation for 44 opportunities out of 60 opportunities. 3. Review of Resident #3's "Resident Monthly Assignments" for 2012 on revealed the following: Bathing- Mon, Wed, Fri. Review of the shower schedule dated revealed the following no documentation for and	A 028		

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A 028	Continued From page 2 Assurance check 5x day. There was no documentation for 10 days. Hearing-Mon, Wed, and Fri- assist with hearing aid care. For 8 days of 21 there was no documentation of care. 4. Review of the Monthy Assignments for 6 additional random residents who require assistance revealed lack of documentation for bathing assistance, ADL assistance, assurance checks, joint limitations, dressing, endurance/mobility, toileting, transfer ability, vital signs, and eating. 5. During an interview with the Health and Wellness Director on [redacted] at 6:00 p.m. she stated she was not aware the ADL sheets were not completed. She confirmed the lack of documentation for the residents did not ensure the ADLs were being completed. Class III Correction Date: [redacted]	A 028		

RICK SCOTT
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
The Fountains At Lake Pointe Woods
3270 Lake Pointe Blvd
Sarasota, FL 34231

Dear Administrator:

Re: CCR #2012004323

This letter reports the findings of a Complaint survey that was conducted on , 2012 by a representative of this office.

Attached is the provider's copy of the State (3020) 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. Staff from this office will conduct a review after to verify that the necessary corrections are in place to correct the deficiencies identified on your survey.

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,

Harold D. Williams
Field Office Manager

bw
Enclosure

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

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