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
	AL11910533	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT SARASOTA	5501 SWIFT ROAD 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 This is the follow-up to Complaint survey CCR# 2012-004901 on through at Emeritus at Sarasota, an Assisted Living Facility. One deficiency was found not to be corrected. This was an uncorrected Class II. At the time of the survey deficiencies were identified.	{A 000}		
{A 025}	58A-5.0182(1) FAC Resident Care - Supervision An assisted living facility shall provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities shall offer personal supervision, as appropriate for each resident, including the following: (a) Monitor the quantity and quality of resident diets in accordance with Rule 58A-5.020, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the individual. (c) General awareness of the resident ' s whereabouts. The resident may travel independently in the community. (d) Contacting the resident ' s health care provider and other appropriate party such as the resident ' s family, guardian, health care surrogate, or case manager if the resident exhibits a significant change; contacting the resident ' s family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (e) A written record, updated as needed, of any significant changes as defined in subsection 58A-5.0131(33), F.A.C., any illnesses which resulted in medical attention, major incidents, changes in the method of medication	{A 025}		

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{A 025}	Continued From page 1	{A 025}		

administration, or other changes which resulted in the provision of additional services.

This Statute or Rule is not met as evidenced by:
Based on observation, record review and interview, the facility failed to provide supervision to meet the needs and safety of 1 (Resident #2) of 17 sampled residents. The facility assessed Resident #2 as a high risk but failed to initiate any intervention to protect the resident. Resident #2 suffered several one resulting in a large

The findings include:

Record review for Resident #2 found an1823 dated which assessed the resident as needing assistance with ambulation and supervision with transfers. The 1823 identified the resident as having an unsteady gait. An entry on the Service Note (SN) documented a on with no injury. The Physician's communication form (PCF) dated documented a resulting in a large The SN dated stated the Resident Aid reported the resident around 1:45 a.m. the resident stated she got up to go to the kitchen and lost her balance and resulting in a large The PCF dated documented resident was observed on the floor no injury. A physician's order sheet dated documented the physician was informed of a at 12:30 resulting in a small to the right knee. The SN dated stated resident observed sitting on the floor in her living "I got up (pointing at her sofa) and came over here, I guess I The daughter who was present pointed out the fact resident was not using a walker.

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{A 025}	Continued From page 2 The Resident's Care Level completed on documented the facility's care level for Resident #2 was "Level 1" Under the section "Transfer" is was noted the resident has been evaluated and is independent in transferring. The Resident's Care Level completed on documented the facility's care level was "Level 4." Under the sections "Transfer" it was noted the resident requires standby assistance or oversight with transfer. The Physical Evaluation for Resident #2 dated under the section "Medical History of Present Illness" states "Patient had a history of at home. Patient has been falling as well in Assisted Living Facility (ALF) and sustained a on left biceps area from a recent Patient also demonstrates increased and transitional stress. On at 10:30 a.m. a random resident identified Resident #2 as having a recent in the entrance of her Resident's #2's relative was present and stated that she had some issues with the facility that her mother has had too many On at 3:22 p.m. the Resident Care Director stated there was no documentation available to indicate the facility has increase assist or supervision to the resident to ensure Resident's #2's safety. Class II Correction Date:	{A 025}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11910533	A. Building B. Wing	7/24/2012

Name of Facility	Street Address, City, State, Zip Code
EMERITUS AT SARASOTA	5501 SWIFT ROAD SARASOTA, FL 34231

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0030 Reg. # 58A-5.0182(6) FAC: 429.28 LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	Waddey, HFES	7-31-12	Waddey for: Jonny Alten, HFE II	7-31-12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Emeritus At Sarasota
5501 Swift Road
Sarasota, FL 34231

Dear Administrator:

This letter reports the findings of a Complaint revisit survey conducted on 2012 through 2012 by representatives of this office. Enclosed is the provider's copy of the Statement of Deficiencies and Plan of Correction (State Form 3020), 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 2012.**

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,

Harold D. Williams
Field Office Manager

Enclosure
bw

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

Fort Myers Field Office
2295 Victoria Avenue,
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372