

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11967402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/12/2012
NAME OF PROVIDER OR SUPPLIER EXCELSIOR OMEGA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 15 DADE AVE SARASOTA, FL 34232		
(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# 2012005430 completed on 9/12/12 at Excelsior Omega, an Assisted Living Facility. All previous citations have been substantially improved or corrected. No deficiencies were cited relevant to the survey during this visit.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

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FM6W12

If continuation sheet 1 of 1

9/20/2012

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11967402	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/12/2012
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Name of Facility

EXCELSIOR OMEGA INC

Street Address, City, State, Zip Code

15 DADE AVE
SARASOTA, FL 34232

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 A0026 Reg. # 58A-5.0182(2) FAC LSC	Correction Completed 09/12/2012	ID Prefix A0093 Reg. # 58A-5.020(2) FAC LSC	Correction Completed 09/12/2012	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By

Reviewed By

Date:

Signature of Surveyor:

Date:

State Agency

Jasmine Hayes, HFES

9-20-12

Jasmine Hayes, SHPS

9-20-12

Reviewed By

Reviewed By

Date:

Signature of Surveyor:

Date:

CMS RO

Followup to Survey Completed on:

8/2/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2597) Sent to the Facility?

YES

NO



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

September 20, 2012

Administrator
Excelsior Omega Inc.
15 Dade Ave
Sarasota, FL 34232

Dear Administrator:

This letter reports the findings of a Complaint survey revisit conducted on September 12, 2012 by a representative of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were 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. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure

