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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 of a Complaint survey, CCR# 2012012089 and CCR#2012012893 conducted at Emeritus at Colonial Park, an Assisted Living Facility, on [redacted]. CCR #2012012089 contained five allegations; four of which were substantiated and cited under A 0025, A 0030, and A 0031. CCR #2012012893 contained one allegation which was substantiated an cited under A 0030.	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	A 025		

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 025	Continued From page 1 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 administration, or other changes which resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on a review of 2 residents who had incident reports related to spilling hot substances and interview with administrative and clinical staff, the facility failed to ensure there was supervision of 2 (Resident #1 and Resident #2)residents. The findings include: 1. The incident reports for Resident #2 were reviewed. The first one was dated [redacted] and indicated on [redacted], the resident had spilled soup on the lap. The documentation indicated the wet clothing was removed as soon as possible. "Assessment of the area nurse notes pink areas on inner thighs left and right. No [redacted]. Resident does not complaint of pain on exam." Interview with the Resident Care Director on [redacted] at 1:55 p.m. indicated the facility practice is to observe residents for 72 hours after an incident and document the observations. Review of Resident #2's record revealed service notes for [redacted] identifying the accident with the injury and stated the physician was notified of the injury. There was no further documentation in the service notes until [redacted] when the staff documented the resident was starting an [redacted] for treatment. There was no documentation of observation of the [redacted] from	A 025		

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 025	Continued From page 2	A 025		

the time of the injury through the time the resident left the facility to go to the hospital on [redacted].

The Resident Care Director confirmed on [redacted] at 3:30 p.m. during a interview that the [redacted] should have been observed. "I could have seen it myself, but didn't." She further stated she was unaware that none of the staff had observed the site. She stated the Resident Care Assistants had been seeing the area regularly, as the resident receives [redacted] care, but none of them had observed the area for [redacted] and notified the nurses about the area.

There was documentation of notification of the physician and family on the date of the injury on [redacted]. There was no follow up documented by the facility about the injury and whether was any treatment to be ordered.

The facility provided a fax that notified the physician of the injury, that was dated on [redacted]. The physician did not sign orders for care until [redacted]. There was documentation indicating the pharmacy received this fax on [redacted]. It was not known when the fax arrived in the assisted living facility.

The order on the fax indicated the facility should contact home health nursing (first home health agency) to get home health to provide [redacted] care to the area. The resident was not receiving care from this agency, but another and had a relationship with the other agency (second home health agency) since [redacted].

The Resident Care Director indicated during interview on [redacted] at 3:30 p.m., she could not confirm when home health was notified about the injury. She indicated she was aware of when the

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 025	Continued From page 3	A 025		

notification to the home health agency the physician ordered. She stated when they investigated they found the resident had a relationship with another home health agency. This was unknown at the facility. The facility then sent the information to the second home health agency with the order.

A review of the documentation that was provided by the second home health agency revealed the registered nurse visited the resident on 10/12/12 indicated the nurse looked at the resident's , but there was no documentation about the area. There was a visit noted dated indicating the resident "has a on her right thigh with open ' The nurse measured the as 4.8 cm (centimeters) by 2.2. cm, by 0.2 cm deep with part open and part with The nurse indicated the facility did not notify her about the . The nurse contacted the physician about the . The had a culture later and showed the resident had resistant aureaus) present.

2. Review of Resident #1's incident report revealed the resident spilled coffee in the lap on at the snack station. "His are red, no other visual injury, he stated I am fine. The resident's family was notified about the injury and the resident's vital signs were taken.

Review of the record revealed at service note dated at 1:40 p.m. which documented the "Resident has no c/o (complained of) pain or discomfort related to recent incident. No s/s (signs and symptoms) of distress noted." On , the service note indicated the resident was "A & O x3 (alert and oriented to person place and time) sitting upright in wheelchair. No c/o

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 025	Continued From page 4 pain or discomfort and no s/s of acute distress." On [redacted]: the service note stated the resident has no complaints no s/s of distress. Interview with the LPN who documented these notes on [redacted] at 1:50 p.m. indicated in response to questioning, it is the practice of the facility to document and observe a resident closely for 72 hours after an incident. He indicated that he did not observe the resident's [redacted] after this incident. He stated he attempted to observe the area, but the resident refused to allow him to visualize the area. He agreed he did not document this refusal in the notes. Class II	A 025		
A 030	58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures (6) RESIDENT RIGHTS AND FACILITY PROCEDURES. (a) A copy of the Resident Bill of Rights as described in Section 429.28, F.S., or a summary provided by the Long-Term Care Ombudsman Council shall be posted in full view in a freely accessible resident area, and included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. (b) In accordance with Section 429.28, F.S., the facility shall have a written grievance procedure for receiving and responding to resident complaints, and for residents to recommend changes to facility policies and procedures. The facility must be able to demonstrate that such procedure is implemented upon receipt of a complaint. (c) The address and telephone number for lodging complaints against a facility or facility staff	A 030		

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 030	Continued From page 5	A 030		

shall be posted in full view in a common area accessible to all residents. The addresses and telephone numbers are: the District Long-Term Care Ombudsman Council, 1(888)831-0404; the Advocacy Center for Persons with 1(800)342-0823; the Florida Local Advocacy Council, 1(800)342-0825; and the Agency Consumer Hotline 1(888)419-3456.
(d) The statewide toll-free telephone number of the Florida Hotline " 1(800)96 or 1(800)962-2873 " shall be posted in full view in a common area accessible to all residents.
(e) The facility shall have a written statement of its house rules and procedures which shall be included in the admission package provided pursuant to Rule 58A-5.0181, F.A.C. The rules and procedures shall address the facility ' s policies with respect to such issues, for example, as resident responsibilities, the facility ' s and tobacco policy, medication storage, the delivery of services to residents by third party providers, resident elopement, and other administrative and housekeeping practices, schedules, and requirements.
(f) Residents may not be required to perform any work in the facility without compensation, except that facility rules or the facility contract may include a requirement that residents be responsible for cleaning their own sleeping areas or apartments. If a resident is employed by the facility, the resident shall be compensated, at a minimum, at an hourly wage consistent with the federal minimum wage law.
(g) The facility shall provide residents with convenient access to a telephone to facilitate the resident ' s right to unrestricted and private communication, pursuant to Section 429.28(1)(d), F.S. The facility shall not prohibit unidentified telephone calls to residents. For facilities with a licensed capacity of 17 or more residents in

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 030	Continued From page 6 which residents do not have private telephones, there shall be, at a minimum, an accessible telephone on each floor of each building where residents reside. (h) Pursuant to Section 429.41, F.S., the use of physical . . . . . shall be limited to half-bed rails, and only upon the written order of the resident ' s physician, who shall review the order biannually, and the consent of the resident or the resident ' s representative. Any device, including half-bed rails, which the resident chooses to use and can remove or avoid without assistance shall not be considered a physical . . . . . 429.28 Resident bill of rights.- (1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to: (a) Live in a safe and decent living environment, free from . . . . . and neglect. (b) Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy. (c) Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that such would be unsafe, impractical, or an infringement upon the rights of other residents. (d) Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9 a.m. and 9 p.m. at a minimum. Upon request, the facility shall make provisions to extend visiting hours for	A 030		

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 030	Continued From page 7	A 030		

caregivers and out-of-town guests, and in other similar situations.
(e) Freedom to participate in and benefit from community services and activities and to achieve the highest possible level of independence, autonomy, and interaction within the community.
(f) Manage his or her financial affairs unless the resident or, if applicable, the resident ' s representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a [illegible] his or her spouse if both are residents of the facility.
(h) Reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals except when prevented by inclement weather.
(i) Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, shall be imposed upon any resident.
(j) Access to adequate and appropriate health care consistent with established and recognized standards within the community.
(k) At least 45 days ' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally [illegible], the guardian shall be given at least 45 days ' notice of a nonemergency relocation or residency termination. Reasons for relocation shall be set forth in writing. In order for a facility to terminate the residency of an individual without notice as

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 030	Continued From page 8	A 030		

provided herein, the facility shall show good cause in a court of competent jurisdiction.
(l) Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.

This Statute or Rule is not met as evidenced by:
Based on interviews, record review, and policy review the facility failed to honor the right to privacy of 1 (Resident #3) of 3 residents reviewed, by allowing an unauthorized third party service provider access to personal and protected health information resident information without written consent of a the resident. The facility also failed to honor the right of 1 (Resident #2) resident's choice of home health agency.

The findings include:

1. Resident #3 was interviewed on at approximately 2:30 p.m. Resident #3 recalled speaking to a representative of the third party service provider (TPSP) in question. Resident #3 denied giving consent for services to be provided by the (TPSP), denied providing the (TPSP) any personal information/billing information. Resident #5 denied being aware the (TPSP) also provided services for her daughter. Resident #5 denied giving consent for her daughter to receive such

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 030	Continued From page 9 services. The Resident Care Director (RCD) was interviewed on [redacted] at 4:01 p.m. The RCD admitted to providing the (TPSP) with personal and protected health information for Resident #3. The RCD stated, "Basically I gave them the history that she [Resident #3] in fact had [redacted] and she had the ostomy done." The RCD denied having written consent from Resident #3 to provide such information the TPSP such information. A review of Resident #3's facility records on [redacted] did not reveal a signed consent form to release information to the (TPSP). On [redacted] the facility ' s policy and procedure for Health Insurance Portability and Accountability Act (HIPAA) was reviewed. The review revealed the facility defines protected health information as consisting, " of information about a resident that is in individually identifiable form and that relates to (1) preventative, diagnostic, therapeutic, rehabilitative, maintenance, or [redacted] care provided to the resident, or (2) assessment, counseling or other services with respect to the resident's physical or mental condition or functional status. It includes all information, regardless of the format, whether in written, oral, or electronic form [45 C.F.R. 164.50]." Further review of the HIPAA policy and procedure revealed the following statement under the policy heading, "[The facility] will not disclose protected health information to outside persons or entities without a written authorization from the resident or the resident's personal representative unless specifically required or permitted to do so by law."	A 030		

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 030	Continued From page 10	A 030		

2. The incident reports for Resident #2 were reviewed. The first one was dated [redacted] and indicated on [redacted], the resident had spilled soup on the lap. The documentation indicated the wet clothing was removed as soon as possible. "Assessment of the area nurse notes pink areas on inner thighs left and right. No [redacted]. Resident does not complaint of pain on exam."

Interview with the Resident Care Director on [redacted] at 1:55 p.m. indicated the facility practice is to observe residents for 72 hours after an incident and document the observations.

There was documentation of notification of the physician and family on the date of the injury on [redacted]. There was no follow through by the facility staff until [redacted] At that time, the service notes indicated the facility received an order for an [redacted], and also noted an order was faxed to the home health agency ordered by the physician to perform [redacted] care.

This resident had a current and ongoing relationship with another home health agency since [redacted] The facility was did not protect the resident's rights for choice related to the home health agency.

The Resident Care Director indicated during interview on [redacted] at 3:30 p.m., she could not confirm when home health was notified about the injury. She indicated she was aware the notification when to the home health agency the physician ordered. She stated when they investigated they found the resident had a relationship with another home health agency. They then sent the information to the second home health agency with the order. The facility

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 030	Continued From page 11 did not honor the resident ' s wishes about choice related to home health agency's use. The home health agency did not evaluate this area until [redacted]. This resident did not receive any care to this [redacted] and later developed an [redacted] in the area. Class II	A 030		
A 031	58A-5.0182(7) FAC Resident Care - Third Party Services (7) THIRD PARTY SERVICES. Nothing in this rule chapter is intended to prohibit a resident or the resident ' s representative from independently arranging, contracting, and paying for services provided by a third party of the resident ' s choice, including a licensed home health agency or private nurse, or receiving services through an out-patient clinic, provided the resident meets the criteria for continued residency and the resident complies with the facility ' s policy relating to the delivery of services in the facility by third parties. The facility ' s policies may require the third party to coordinate with the facility regarding the resident ' s condition and the services being provided pursuant to subsection 58A-5.016(8), F.A.C. Pursuant to subsection (6) of this rule, the facility shall provide the resident with the facility ' s policy regarding the provision of services to residents by non-facility staff. This Statute or Rule is not met as evidenced by: Based on a review of 4 residents, who had incident reports related to spilling hot substances and interview with administrative and clinical staff, the facility failed to ensure there was effective communication and coordination between the third party provider and the facility for 1 (Resident	A 031		

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 031	Continued From page 12 #2) of 4 residents resulting in lack of care and an The findings include: 1. The incident reports for Resident #2 were reviewed. The first one was dated . . and indicated on the resident had spilled soup on the lap. The documentation indicated the wet clothing was removed as son as possible. "Assessment of the area nurse notes pink areas on inner thighs left and right. No Resident does not complaint of pain on exam." There was documentation of notification of the physician and family on the date of the injury on . . . . . There was no follow through by the facility staff until . . . . . At that time, the service notes indicated the facility received an order for an , and also noted an order was faxed to a home health agency to perform . . . . care. The Resident Care Director indicated during interview on . . . . . at 3:30 p.m., she could not confirm when home health was notified about the injury. She indicated she was aware the notification when to the home health agency the physician ordered. She stated when they investigated they found the resident had a relationship with another home health agency, but the facility was unaware of which one it was. They then sent the information to the second home health agency with the order. There was documentation of a fax that notified the physician of the injury. He did not sign orders for care until . . . . . There was documentation indicating the facility's pharmacy received this fax on . . . . . (11 days after the injury). The order	A 031		

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
	AL11963982	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT COLONIAL PARK	4730 BEE RIDGE ROAD SARASOTA, FL 34233

(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 031	Continued From page 13 on the fax indicated the facility should contact home health nursing (first home health agency) to get home health to provide care to the area. The resident was not receiving care from this agency, but another and had a relationship with the other agency (second home health agency) since A review of the documentation that was provided by the second home health agency revealed the registered nurse visited the resident on indicated the nurse looked at the resident's but there was no documentation about the area. There was a visit note dated indicating the resident "has a on her right thigh with open ' The nurse measured the area as 4.8 cm (centimeters) by 2.2. cm, by 0.2 cm deep with part open and part with The nurse indicated the facility did not notify her is the indicated. The nurse contacted the physician about the . The had a culture later and showed the resident had resistant aureaus) present. Class III	A 031		

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Emeritus at Colonial Park
4730 Bee Ridge Road
Sarasota, Florida 34233

Dear Administrator:

Re: CCR #2012012089 and 2012012893

This letter reports the findings of a complaint survey that was conducted on , 2012 by representative(s) 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 2013 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(s). Should you have any questions please call this office at 239-335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

HW:ss
Enclosure: Stat Form

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