STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11967402	**07/15/2013**
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Excelsior Omega Inc	**15 Dade Ave Sarasota, FL 34232**	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

List of Tags Cited:
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D

These are the results of a Complaint Survey, CCR# 2013006902 conducted on . . . through . . . . . at Excelsior Omega, an Assisted Living Facility (ALF).

There were 3 allegations in this complaint one of which was confirmed. There was a deficiency cited at A30.

The following is a description of non-compliance:

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation, the facility failed to ensure the building was in good repair.

The findings include:

A tour of the facility was performed. The following was observed during the tour on . . . . . at 10:30 a.m. and on . . . . . at 9:30 a.m.:

a. The door knob on . . . . . would not catch and the door would not remain closed.

b. The door on sticks and cannot be opened easily. The door has to be forced open.

c. The hallway through the dining area outside of the kitchen area had a black streak approximately 1 foot off the floor. During an interview staff touring with the surveyor stated that it is from the wheelchairs going by the wall. She stated she has fixed it several times and it doesn't remain fixed.

d. In the resident's . . . is a walk in shower with tile surrounding it. The corner was broken, the tiles were broken and sharp.

Class III

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Excelsior Omega Inc
15 Dade Ave
Sarasota, FL 34232

Re: CCR #2013006902

Dear Administrator:

This letter reports the findings of a Complaint survey that was completed on . 2013 by a representative of this office.

Attached is the provider's copy of the State (5000-3547) 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. Should you have any questions please call this office at (239) 3351315.

Sincerely,

Harold D. Williams
Field Office Manager

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Enclosure: State Form

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