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	AL11910533	08/07/2014
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List of Tags Cited:
St - A - 0025 - 58a-5.0182(1) Fac - Resident Care - Supervision S-S= D
St - A - 0028 - 58a-5.0182(4) Fac - Resident Care - Activities Of Daily Living S-S= D
St - A - 0030 - 58a-5.0182(6) Fac; 429.28 Fs - Resident Care - Rights & Facility Procedures S-S= D
St - A - 0052 - 58a-5.0185(3) Fac - Medication - Assistance With Self-Admin S-S= D
St - A - 0076 - 58a-5.0186 Fac - S-S= D
St - A - 0079 - 58a-5.019(3) Fac - Staffing Standards - Levels S-S= D
St - A - 0081 - 58a-5.0191(2) Fac - Training - Staff In-Service S-S= D
St - A - 0082 - 58a-5.0191(3) Fac - Training - S-S= D
St - A - 0083 - 58a-5.0191(4) Fac - Training - First Aid And S-S= D
St - A - 0086 - 58a-5.0191(9) Fac - Training - Adrd S-S= D
St - A - 0090 - 58a-5.0191(11) Fac - Training - S-S= D
St - A - 0091 - 58a-5.0191(12) Fac - Training - Documentation & Monitoring S-S= D
St - A - 0093 - 58a-5.020(2) Fac - Food Service - Dietary Standards S-S= D
St - A - 0151 - 58a-5.023(2) Fac - Physical Plant - Existing Facilities S-S= D

Specific Tag Findings:
An unannounced Biennial survey was completed on through at Emeritus at Sarasota, an Assisted Living Facility (ALF) in Sarasota, Florida.

The following is the description of non-compliance:

0025-Resident Care - Supervision 58A-5.0182(1) FAC
Based on record review, observation and interview, the facility failed to provide supervision of 2 (Residents #5 and #23) of 24 residents for safety and maintaining a general awareness of the residents' whereabouts. The facility failed to ensure proper positioning for 1 (Resident #15) resident. The facility failed to monitor the quality and quantity of the therapeutic diets for 10 (Residents #6, #8, #9, #17, #18, #19, #20, #21, #25 and #28) of residents reported by the kitchen to have therapeutic diets. The lack of communication from nursing to dietary potentially fails to ensure each resident is served the diet ordered by the physician.

The findings include:

1. Record review on reveals Resident #5 has a long history of outbursts of aggressive behaviors toward staff members. Further review of the record revealed Resident #5 has been found in a female Resident #23's bed, holding hands and pursuing her against her guardian's wishes. Resident #5 had repeatedly been instructed to stay away from Resident #23, but Resident #5 continued to pursue Resident #23 as recently as

Record review for nursing notes dated state, "Resident and female resident were unable to be located. Staff searched in house and parking lot. Resident was found next door at Manor Care. Requested return to facility. Upon return, this resident and another (Resident #23) were angry and spoke as such to each other on the first floor and again later in hallway upstairs."

An interview was conducted with Staff B, Health and Wellness Director, on at 11:10 a.m. Staff B stated the evening and night shift monitor Resident #5's whereabouts. She is not sure how often this monitoring occurs. Monitoring of Resident #5's whereabouts was not documented.

Interview with Staff F, Medication Assistant and Caregiver on at 2:50 p.m., revealed this staff member has no knowledge of any inappropriate relationships between Residents #5 and #23. He stated that he is unaware of

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any monitoring process.

Multiple observations on and revealed that Resident #5 was allowed to wander freely throughout the facility without supervision during the day.

2. Observations of Resident #15 on and for any time the resident was out of bed, she was in a wheelchair. The resident was twisted laterally at approximately a 90 degree angle to the left side. The resident was observed throughout the survey in this position. Review of the resident's record revealed the resident had an order for a positioning device on

Interview with Staff Q at 12:55 p.m. on revealed they had noticed the resident leaning. They had a bolster from another resident who had left and they got an order to try this for the resident. Staff Q further stated, "It worked pretty well" unless the resident removed it. Staff Q agreed the staff did not evaluate the resident for the most effective device for the positioning issue.

3. Prior to the noon meal a list of therapeutic diets was requested from the Food Service Director. The list contained 12 residents on a Consistent diet (CCHO), some with limited concentrate sweets (LCS), along with 1 resident on mechanical soft and 2 residents on a puree diet.

The extend menu listed a regular diet as shredded BBQ pork sandwich, Yukon gold potato wedges and beet apple salad, with the soup of the day listed as savory and the dessert as banana drop cookie.

On the dining the soup was listed as chicken and rice and the alternate desert as ice cream, sherbet, sugar free Jell-O with whipped topping. The exchange for mechanical soft was ground meat and omits skins on the potatoes with spiced apples in place of the beet and apple salad. The exchange for the CCHO was omit BBQ sauce use mayonnaise, 2 ounces less of potatoes and sugar cookie in place of the banana drop cookie.

Observation of the tray line revealed BBQ pork, potatoes and beet and apple salad. When asked the cook, Staff X, verified she had not ground any BBQ pork, had not made spiced apples, had not made any pork without BBQ sauce and had no sugar cookies. She was unable to serve the therapeutic diets as ordered by physicians and planned on the extended menu.

List provided by Staff M, Dining Services Director:

Resident #28 was listed by the kitchen as CCHO/LCS. Review of the AHCA Health Assessment Form 1823, dated ordered a Low Fat, Low ol/CCHO diet. The facility was not monitoring to ensure the low fat low order was followed.

Resident #16, listed as a CCHO/LCS diet by the kitchen. On he was observed served a BBQ sandwich, potatoes, apple/beet salad, and a banana drop cookie. Review of the AHCA Health Assessment Form 1823, Diet order dated as regular. A diet option communication form dated listed the resident as regular. The facility was not monitoring to ensure the kitchen and nursing listed the correct diet for this resident.

Resident #9, listed by the kitchen as CCHO/LCS. Review of the AHCA Health Assessment Form 1823, Diet order dated as regular. The facility was not monitoring to ensure the kitchen and nursing listed the correct diet for this resident.

Resident #17, listed by the kitchen as CCHO/LCS was served a BBQ sandwich, potatoes, apple/beet salad, and a

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banana drop cookie. Review of the AHCA Health Assessment Form 1823, dated ..... listed the diet as CCHO. The facility was not monitoring to ensure the resident was served the therapeutic diet as ordered.

Resident #6, listed by the kitchen as CCHO/LCS/NAS was served a BBQ sandwich, potatoes, apple/beet salad, and a banana drop cookie. Review of the AHCA Health Assessment Form 1823, dated listed the diet as calorie controlled/NAS. On the facility contacted the physician and changed order to CCHO. The facility was not monitoring to ensure the resident was served the therapeutic diet as ordered.

Resident #18, listed by the kitchen as CCHO/LCS was served a 1/2 turkey on rye with tomato. Review of the AHCA Health Assessment Form 1823, dated listed the diet as regular. The facility was not monitoring to ensure the kitchen and nursing listed the correct diet for this resident.

Resident #19, listed in the kitchen as CCHO/LCS was served a turkey sandwich and chips. Review of the AHCA Health Assessment Form 1823, dated listed the diet order as regular. A facility diet option communication form dated listed the diet as CCHO. The facility was not monitoring to ensure the kitchen, nursing and physician had the same diet for this resident.

Resident #20, listed by the kitchen as Mechanical soft (ground meat), was served BBQ pork not ground, skin on potatoes and beet/apple salad. Review of the AHCA Health Assessment Form 1823, dated ..... listed the diet as regular. The facility care plan says Mechanical soft. The facility was not monitoring to ensure the kitchen, nursing and physician had the same diet for this resident.

Resident #8, listed by the kitchen as puree with comfort foods was served regular chicken noodle soup with noodles and chunks of meat and vegetables and whole cookies. Review of the AHCA Health Assessment Form 1823, dated listed the diet as puree, thin liquids, no straws. The facility resident assessment dated ..... listed the diet as regular puree. A diet option communication form dated listed the diet as puree with mechanical soft pleasure foods. There is no evidence to show what the physician intended as pleasure foods. The facility was not monitoring to ensure the kitchen, nursing and physician had the same diet for this resident.

Resident #21, listed by the kitchen as CCHO/LCS was served BBQ sandwich, potatoes, apple/beet salad, and a banana drop cookie. Review of the AHCA Health Assessment Form 1823, dated ..... listed the diet as calorie controlled. The facility resident assessment dated under Nutrition/Eating: CCHO/LCS. The facility was not monitoring to ensure the resident was served the therapeutic diet as ordered.

Resident #25, listed by the kitchen as CCHO/LCS was served BBQ sandwich, potatoes, apple/beet salad. Review of the AHCA Health Assessment Form 1823, dated listed the diet as CHO. The facility resident assessment dated ..... under Nutrition/Eating: NAS/ CCHO/LCS.

All were served banana drop cookie, or ice cream. The CCHO diet is supposed to have a sugar cookie.

Class III

0028-Resident Care - Activities of Daily Living 58A-5.0182(4) FAC
Based on interview, review of grievance logs and record review, the facility failed to ensure there was assistance with Activities of Daily Living (ADL) provided for 3 (Residents #9, #13, and #14) of 15 resident reviewed for ADLs.

The findings include:

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1. Review of the grievance council revealed residents were reporting they were supposed to get bathing help, but were not receiving it from staff. The residents stated the aides were to come on Monday and Thursday, and did not show up for the assistance. One resident reported he required assistance with "salve" and they did not come to help him. On the minutes one resident continued to report the staff did not come to help him with his bathing activities.

2. Interview with Staff O on at 10:15 a.m., revealed there is a book located in each medication gives a bath schedule for each resident. The book also has forms for the aide to document care on an ADL sheet. The aide is to initial and sign and there is a space on the form for the aide to document any care not completed. None of the forms review for the first and second floors had any documentation indicating the staff did not provide any care for residents, including Residents #9, #13 and #14.

3. Interview on at 11:15 a.m. with Resident #9 revealed staff sometimes watches him when he showers, but not all the time. He has and was hospitalized recently. Staff are supposed to watch him to ensure he does not again, but don't always do it.

4. Interview on at 2:50 p.m. with Resident #13 revealed the facility is down to 1 person on each floor except when training. She stated, "Turnover is terrible. The reason is they are overworked. I think they pay 10.00 and uniforms and maybe meals. I do not think there is enough staff. We had two (resident aides) on each floor up until 2-3 months ago."

She stated staff had no trouble respond to her call light usually. She uses a bed side commode at night. However, 7-8 times her bed side commode was not emptied by p.m., when she was ready for bed. She stated she gets no assistance for showers. The resident aide was allowed to supervised her shower and wash her with a nozzle, when she first moved in. But after 30 days they said that was length of time she could have that service. She stated she can do showers by herself now.

She stated she does not think they give the staff enough training. The biggest problem between residents and staff is the lack of ability to hear. Not everyone has hearing aides who need them, and staff is not trained in how to communicate with someone who has a hearing problem, so they just do what they think is needed.

5. Interview on at 3:00 a.m. with Resident #14 revealed she is concerned about the turnover in staff. She said they have lost many good staff lately, even nurses. She says they were being written up and not really provided with training. She thinks if they worked with staff and provided training they would do better. Thinks they need more training in how to work with the elderly.

Class III

0030-Resident Care - Rights & Facility Procedures 58A-5.0182(6) FAC; 429.28 FS
Based on observation and interview, the facility failed to follow control practices during meal service for 2 (Staff G and H) of 3 staff observed serving meals and for 1 (Staff P) of 3 staff observed for medication pass.

The findings include:

1. On at 11:30 a.m. Staff G and H (wait staff) were observed serving lunch without wearing gloves. Both staff touched the inside rim of the resident's plates with their fingers as they served lunch. Neither staff member was observed to wash hands between serving residents, or used sanitizer.

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Staff G was observed to return dirty dishes to the kitchen scrape them and stack them with other dirty dishes by the dishwasher. She did not wash her hands before picking up another plate of food and touching the food surfaces of the resident's plates, carry them out to the residents. The next time she returned with dirty dishes, Staff G was again observed to scrape and stack the plates, but did wash her hands for a count of 3, before drying them. She was observed to move the lid of the garbage receptacle with her left hand and throw away the used paper towel with her right hand. She then picked up residents plates in both hands while touching the food surface.

2. The electric soup tureen near the dining was observed uncovered from 11:50 a.m. to 12:35 p.m. at which time Staff G placed the cover onto the tureen.

3. Interview with Staff M, Dining Services Director on revealed that wait staff should wash hands between serving residents and wear gloves while serving residents.

4. The medication pass in the memory care unit was begun on at 8:22 a.m. Staff P performed the medication pass. The staff member used gloves throughout the procedure, but never washed her hand at any time during the medication pass for the 2 observed residents.

Class III

0052-Medication - Assistance with Self-Admin 58A-5.0185(3) FAC
Based on record review, observation and interview, the facility failed to ensure all staff provided assistance with self-administration of medications for 1 (Resident #6) of 5 residents observed during med pass and 3 (Residents #6, #8, and #9) of 11 residents interviewed.

The findings include:

1. On at 9:50 a.m., Staff C, who is not a nurse, was observed to cleanse her hands with hand sanitizer. She then pushed the medication cart to Resident #6's She knocked on the resident's door and informed her she was here to give her medication. She consulted the Medication Observation Record (MOR) and removed medications from the resident's supply. She poured the medications into a paper cup and took them into the resident's She gave the resident the medication cup with medication in them. The resident counted the number of medications in the paper cup and swallowed them with water. Staff C exited the documented the medications as given. Medications were not dispensed in the presence of the resident, nor were the resident informed of what medication she was receiving.

2. Interview with Staff C on at 10:00 a.m. revealed she is not aware she must dispense medications in the presence of the resident. She states she is also not aware she must inform the resident of the medications being given.

3. Interview with Resident #6 on at 10:15 a.m. revealed, she get assistance with her medications. Staff usually brings them to her If she misses them then she goes down there (medication She stated, "Last night's medications did not come until 9:30 p.m. Staff doesn't seem to get things done. I get my shot from my daughter. I am so I take my sugar every morning myself." She stated she just takes the pills she is given but is not sure of what all they do. Staff does not tell her what she is taking or what they are for. She stated she sees 5 different doctors. She is supposed to get something at 6 a.m. and

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usually gets it at 7:00 a.m. instead.

4. Interview with Resident #9 on at 11:15 p.m. when asked about assistance with medications, revealed staff will tell him what he is taking if he asks. Their protocol would be to take the medications in front of them. They strictly watch you take it. He stated the staff just put the medicine in a pill cup and do not tell him what he is taking, and then watch him take them.

5. Interview with Resident #8 on at 10:46 a.m. revealed staffs assist her with her medications. She stated they tell her what she is taking because she asks them each time just to make sure what she is taking.

Class III

007(58A-5.0186 FAC
Based on interview and review of the facility's policy and procedure related to and policy, the facility failed to ensure there was a system in place for the staff to be aware of the wishes of residents for 4 (Staff B, E, L, and Q) of 4 staffed interviewed for the policy.

The findings include:

1. Interviews were performed with Staff B, E, L, and Q. In each interview the staff was asked how they knew which resident had Staff B and E was asked together on at 2:05 p.m., how they knew this information and they were unable to state the system. They both indicated the resident's record would have this information. Both of these staff works on the locked memory care unit which is down the hall and around the building to get to the nursing station where the records are kept.

Interview with the Memory Care Director (Staff L) on at 2:30 p.m., revealed she doesn't know how staff is supposed to know this information. She stated she was going to establish a book to keep in the medication the unit for this information, but since she is new, it hasn't been done as yet.

Interview with Staff Q at 12:55 p.m. on revealed if the staff found a resident in , they are supposed to start then stop when the paramedics arrive.

2. A review of the policy and procedure for revealed the following information:

Policy:
"We value each resident's decision about the type of care and treatment they wish to receive. Depending on a resident's medical condition, personal needs and beliefs, he or she may choose to implement a order....

Procedure:
Community shall maintain copies of provided to them by the resident and/or responsible party. The state of Florida supplies and recognizes the Florida Department of Health, State of Florida, (DH Form 1896) for this purpose. This form must be printed on yellow paper prior to being completed. The community staff has the opportunity to discuss these wishes with the resident and any other concerned parties.

Resident may review or revise his or her at any time.

During an emergency, it is our policy to call 911. In the event a resident experiences , staff

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trained in or a licensed health care provide present in the community, may withhold

In the event a resident is receiving hospice services and experiences community staff shall notify the hospice agency.

Community will make every attempt to provide copies of to emergency personnel or other appropriate parties."

Class III

0079-Staffing Standards - Levels 58A-5.019(3) FAC
Based on record review and interview, the facility failed to staff the night shift with a staff person certified in first aid and

The findings include:

1. A review of the work schedule for the night shift revealed Staff E, , T, U, and W work 10:00 p.m. to 6:00 a.m.

A review of personnel records for Staff E, , T, U, and W revealed only Staff U was current in certification for first aid and

A review of the work schedule for 1-17 , revealed the facility scheduled 6, 7, 11, and 16 with no FA/(coverage.

2. Interview with the Staff B, Resident Care Director on at 2:30 p.m., revealed the facility had nurses from 7:00 a.m. to 10:00 p.m. and only needed one staff in the building with FA and , therefore she did not train all care staff in first aid and . She was told she had 2 nights this month she failed to staff for coverage, only had 1 night staff who was qualified, and had no coverage scheduled for tonight. She stated she would fix it.

Class III

0081-Training - Staff In-Service 58A-5.0191(2) FAC
Based on record review and interview, the facility failed to ensure all direct care staff receive required training within 30 days of hire for 2 (Staff E and F) of 6 direct care staff reviewed.

The findings include:

1. Personnel Record review on revealed Staff E was hired as a direct care staff on and Staff F was hired as a direct care staff on

A review of the personnel records for these two staff revealed Staff E and F lacked training in the 2 hour AID, Elopement response, Emergency preparedness and evacuation, incident reporting, Resident Rights, and Recognizing and reporting , neglect and . Staff E also lacked training in Nutrition and safe food handling.

2. On around 2:00 p.m. Staff N verified the information available was filed in the personnel records for both

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staff.

Class III

0082-Training - 58A-5.0191(3) FAC
Based on record review and interview, the facility failed to ensure all direct care staff receive required within 30 days of hire for 2 (Staff E and F) of 6 direct care staff reviewed.

The findings include:

1. Personnel Record review on revealed Staff E was hired as a direct care staff on and Staff F was hired as a direct care staff on

A review of the personnel records for these two staff revealed Staff E and F lacked training in the 2 hour

2. On around 2:00 p.m. Staff N verified the information available was filed in the personnel records for both staff.

Class III

0083-Training - First Aid and 58A-5.0191(4) FAC
Based on record review and interview, the facility failed to staff the night shift with a staff person certified in first aid and

The findings include:

1. A review of the work schedule for the night shift revealed Staff E, T, U, and W work 10:00 p.m. to 6:00 a.m.

A review of personnel records for Staff E, T, U, and W revealed only Staff U was current in certification for first aid and

A review of the work schedule for 1-17 revealed the facility scheduled 6, 7, 11, and 16 with no FA/C coverage.

2. Interview with the Staff B, Resident Care Director on at 2:30 p.m. revealed the facility had nurses from 7:00 a.m. to 10:00 p.m. and only needed one staff in the building with FA and therefore she did not train all care staff in first aid and She was told she had 2 nights this month she failed to staff for coverage, only had 1 night staff who was qualified, and had no coverage scheduled for tonight. She stated she would fix it.

Class III

0086-Training - ADRD 58A-5.0191(9) FAC
Based on record review and interview, the facility failed to ensure all direct care staff receive required 4 hours of initial and Related (ADRD) within 3 months of hire for 2 (Staff D and F) of 6 direct care staff reviewed and additional 4 hours level II training within 9 months of hire for 1 (Staff D) of 6 direct care

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staff reviewed.

The findings include:

1. Personnel Record review on revealed Staff D was hired as a direct care staff on , and Staff F was hired as a direct care staff on .

A review of the personnel records for these two staff revealed Staff D and F lacked training in the 4 hour initial ADRD training. Further review revealed Staff D lacked the level II ADRD training needed within 9 months of hire.

2. On around 2:00 p.m. Staff N verified the information available was filed in the personnel records for both staff.

Class III

0090-Training - 58A-5.0191(11) FAC
Based on record review and interview, the facility failed to ensure all direct care staff receive required the facility's policy within 30 days of hire for 3 (Staff C, E, and F) of 6 direct care staff reviewed.

The findings include:

1. Personnel Record review on revealed Staff C was hired as a direct care staff on . Staff E was hired as a direct care staff on ; and Staff F was hired as a direct care staff on .

A review of the personnel records for these three staff revealed Staff C, E, and F lacked training in the facility's policy.

2. On around 2:00 p.m. Staff N verified the information available was filed in the personnel records for both staff.

Class III

0091-Training - Documentation & Monitoring 58A-5.0191(12) FAC
Based on record review and interview, the facility failed to ensure all documentation of training provided to staff included the training program agenda, hours of training, location of the training program, trainer's dated signature, credentials and professional license number when applicable for 6 (Staff A, C, D, E, F, and L) of 11 staff reviewed.

The findings include:

1. Personnel Record review on revealed Staff L, was hired as a direct care staff on .

A review of the personnel records for Staff L revealed a certificate for training dated from Staff A, Executive Director. The certificate was for completing Orientation Training including: Notices of Privacy Practices; Manor Incidents, Adverse Incidents and Facility Emergency Procedures; Residents Rights, Neglect; Elopement; 1; Control, Universal Precautions & Facility Sanitation; Bloodstone Safe Food Handling; and Ergonomics.

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No hours were noted for any courses. If courses were completed to meet the required training time noted in the regulations, the training given on ... would have taken over 12 hours to complete. The certificate lacked the credentials of the trainer, program agenda and location of the training program.

2. Personnel Record review on ... revealed Staff A, Executive Director, had documentation of training classes in ... and ... of 2014. These certificates of completion lacked the agendas.

3. Personnel Record review on ... revealed Staff C, was hired as a direct care staff on ...

A review of the personnel records for Staff C revealed a certificate for training dated ... from Florida CNA Skills Center, Inc. listing subjects taken during a 75 hour course. There was no agenda and many subjects lacked hours. The course did not report any bathing training other than 'Partial bed bath/p ... care/c... cleaning', nor any 'Resident Behavior and Needs' training. The dates of the actual training was not present, just the reported completion date. A review of the Department of Health website revealed Staff C was not a Certified Nursing Assistant.

4. Personnel Record review on ... revealed Staff D, was hired as a direct care staff on ...

A review of the personnel records for Staff D revealed two certificates for training dated ... from Emeritus for Activities of Daily Living (ADL) and Resident Behaviors and ... Policy ... These two certificates lacked the agendas, credentials of the trainer and location of training.

5. Personnel Record review on ... revealed Staff E, was hired as a direct care staff on ...

A review of the personnel records for Staff E revealed a certificate for training dated ... from Florida CNA Skills Center, Inc. listing subjects taken during a 75 hour course. There was no agenda and many subjects lacked hours. The course did not report any bathing training other than 'Partial bed bath/p ... care/c... cleaning', nor any 'Resident Behavior and Needs' training. The dates of the actual training was not present, just the reported completion date. A review of the Department of Health website revealed Staff E was not a Certified Nursing Assistant.

6. Personnel Record review on ... revealed Staff F, was hired as a direct care staff on ...

A review of the personnel records for Staff F revealed a certificate for training dated ... from Florida CNA Skills Center, Inc. listing subjects taken during a 75 hour course. There was no agenda and many subjects lacked hours. The course did not report any bathing training other than 'Partial bed bath/p ... care/c... cleaning', nor any 'Resident Behavior and Needs' training. The dates of the actual training was not present, just the reported completion date. A review of the Department of Health website revealed Staff F was not a Certified Nursing Assistant.

7. On ... around 2:00 p.m. Staff N verified the information available was filed in the personnel records for all staff.

Class III

0093-Food Service - Dietary Standards 58A-5.020(2) FAC
Based on observation, interview and record review, the facility failed to ensure therapeutic diets ordered by the physician were followed as prescribed for 6 (Residents #6, #8, #17, #20, #21, and #25) of 12 observed resident

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11910533	08/07/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE	
Emeritus At Sarasota	5501 Swift Road Sarasota, FL 34231	
SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

reported to have therapeutic diets.

The findings include:

1. Prior to the noon meal a list of therapeutic diet was requested from the Food Service Director. The list contained 12 residents on a Consistent diet (CCHO), some with Limited Concentrate Sweets (LCS), along with 1 resident on mechanical soft and 1 resident on a puree diet.

The extend menu listed a regular diet as shredded BBQ pork sandwich, Yukon gold potato wedges and beet apple salad, with the soup of the day listed as savory and the dessert as banana drop cookie.

On the dining the soup was listed as chicken and rice and the alternate desert as ice cream, sherbet, sugar free Jell-O with whipped topping. The exchange for mechanical soft was ground meat and omits skins on the potatoes with spiced apples in place of the beet and apple salad. The exchange for the CCHO was omit BBQ sauce use mayonnaise, 2 ounces less of potatoes and sugar cookie in place of the banana drop cookie.

2. Observation of the tray line revealed BBQ pork, potatoes and beet and apple salad. When asked the cook, Staff X, verified she had not ground any BBQ pork, had not made spiced apples, had not made any pork without BBQ sauce and had no sugar cookies. She was unable to serve the therapeutic diets as ordered by physicians and planned on the extended menu.

3. Observation of the noon meal on revealed:

a. Resident #6, listed from the kitchen as CCHO/LCS was served the BBQ pork sandwich, potatoes and beet/apple salad. A review of the AHCA Health Assessment Form 1823 dated ordered calorie controlled/no added salt. On a physician contact changed the order to CCHO.

b. Resident #8, listed from the kitchen as puree with comfort foods was served chicken and noodle soup and banana drop cookie. A review of the AHCA Health Assessment Form 1823 dated listed the diet as puree, thin liquids, no straws. A dietary option communication form dated puree with mechanical soft pleasure foods. mechanical soft with pleasure foods.

c. Resident #17, listed from the kitchen as CCHO/LCS was served the BBQ pork sandwich, potatoes and beet/apple salad. A review of the AHCA Health Assessment Form 1823 dated revealed the physician ordered a CCHO diet.

d. Resident #20, listed from the kitchen as Mechanical soft (ground meat) was served BBQ pork not ground, skin on potatoes and beet/apple salad. A review of the AHCA Health Assessment Form 1823 dated listed the diet as regular. The facility care plan listed her as Mechanical soft.

e. Resident #21, listed from the kitchen as CCHO/LCS was served the BBQ pork sandwich, potatoes and beet/apple salad. A review of the AHCA Health Assessment Form 1823 dated listed the diet order as calorie controlled. A Facility resident assessment form dated listed under Nutrition/Eating: Consistent diet - CCHO/Limited Concentrated Sweets.

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f. Resident #25, listed from the kitchen as CCHO/LCS was served the BBQ pork sandwich, potatoes and beet/apple salad. A review of the AHCA Health Assessment Form 1823 dated listed the diet ordered as CHO. The facility resident assessment form dated , listed under Nutrition/Eating: NAS/CCHO/LCS.

g. All residents were served banana drop cookies. Some got ice cream.

2. An observation of dinner on at 4:45 p.m. was performed in the memory care unit. The resident at one table required staff to feed her. Staff served the meal to all other residents and served this resident last, but did not immediately start to help the resident with the meal. Once staff did start to feed the resident, they stood over her and did not sit down at the resident's level.

The staff serving the food onto the plates, was asked how she knew what to serve to each resident for volume, she stated she had no idea. She stated she just started last week, and no one ever taught her. During the dinner service, the staff came to the tables in the memory care unit with the specialty meal and its substitute. Each resident was offered a choice. Once the resident chooses a plate, the plate was given to the resident to eat. The staff then went back to the serving table to get another plate to replace the one chosen. This left one resident at the table eating and the rest waiting to make their choice.

An interview was performed with the Senior Dining Director on at 3 p.m. During the interview she stated the diet order for each resident is posted for the cooks daily so they are aware of it at a glance. The serving area has "cheat sheets" with this information. The serving staff is supposed to inform the residents if they are requesting food that is not on their menu. The resident can choose to request this food anyway, but the servers are supposed to notify the nurse about this. Continued interview stated the staff is supposed to bring the 2 plates to the table in the memory care unit and offer them to each resident. Once the choice is made, a staff will bring the total number of each serving to the entire table so they can eat together. She was unaware it was not being done individually in this manner.

Class III

0151-Physical Plant - Existing Facilities 58A-5.023(2) FAC
Based on observation and interview, the facility failed to ensure the physical plant was clean and in good repair.

The findings include:

1. Tour began at 9:30 a.m. on the second floor. The following was observed:

a. The laundry second has a large accumulation of lint behind the dryers and between the dryer and vent cabinet.

b. base board by window under a/c is rotting.

c. storage area had condensation on ceiling tiles.

d. recently vacated has a stain on counter top in

e. common running and will not shut off. Toilet is stained and continually running.

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SUMMARY STATEMENT OF DEFICIENCIES (FINDINGS PRECEDED BY TAG AND REGULATORY IDENTIFYING INFORMATION)		

f. stain on ceiling tile in the hallway outside the medication

g. walls are scared and marked.

h. large carpet stain in entryway, Staff A, Executive Director stated the carpet was changed 6 months ago.

i. stained and walls scratched. Staff A stated the carpets are cleaned twice a year and cleaned or replaced when move out.

h. Beauty Salon has wall damage and use of multiple for equipment.

j. paint peeling on hanging mirror came off wall, took paint, using non-grounded multiples.

h. gouge in wall,

i. ceiling by 200 wing Staff I, maintenance, stated air unit missing second floating drip pan. One can't be made, so it has to drip. 7 ceiling tiles stain, one tile had hole punched through it. but in for new roof.

j. the refrigerator was plug into a non-grounded cord and run through the jam into a socket.

k. Medication broken linoleum tile was dirty between tiles, The cabinet below the sink has water damage, discolorations and smelled musty.

l. has two multi plugs one direct and other non-grounded.

2. During an interview with Resident #14 on at 3:00 p.m. she stated her sink gurgles when then the toilet is flushed. The toilet was flushed twice and the sink gurgled loudly both times.

3. During the noon dining observation on , the resident in stated the toilet has been a problem since he moved in and was a problem for the last resident who lived in that

4. Observation on at 2:00 p.m. revealed in the wall was scrapped approximately 8 feet; the inside door to the scrapped and dirty; and the wall by the closet was scrapped the entire length of the wall.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

2014

Administrator
Emeritus At Sarasota
5501 Swift Road
Sarasota, FL 34231

Dear Administrator:

This letter reports the findings of a Biennial survey that was conducted on , 2014 by representatives 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 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 surveyors. Should you have any questions please call this office at (239) 335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

sh
Enclosure: State Form

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