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
	AL11964810	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT CONWAY	5501 EAST MICHIGAN STREET ORLANDO, FL 32822

(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 conducted Assisted Living Facility with Limited Nursing Services biennial re-licensure survey. CCR#2012006647 and CCR#2012006753 were conducted at that time. Emeritus Conway had a deficiency found at the time of the visit.	A 000		
AN278	58A-5.031(3) FAC LNS - Records (3) RECORDS. (a) A record of all residents receiving limited nursing services under this license and the type of service provided, shall be maintained. (b) Nursing progress notes shall be maintained for each resident who receives limited nursing services. (c) A nursing assessment conducted at least monthly shall be maintained on each resident who receives a limited nursing service. This Statute or Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure for 2 of 6 sampled residents (#4 and #6) who received a Limited Nursing Service; nursing progress notes were maintained for the residents. Findings: 1. Record review for resident #4 revealed an Assisted Living Facility Health Assessment Form (1823) dated with diagnoses of , normal pressure , with and The resident needed supervision with eating and	AN278		

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AN278	Continued From page 1 assistance with ambulation, bathing, dressing, toileting and transferring. The resident was admitted on . Observation on at approximately 1:45 PM revealed the resident had an ankle brace on a table next to the bed. Interview with the resident at that time who stated she did not have the use of her right hand. Interview with the unlicensed staff at that time stated they put the right ankle brace on and took it off, and she did not wear it every day. The resident was not identified as being on LNS during the entrance conference. There was no documentation to indicate a physician order was obtained to apply and removed the brace and there were no nursing progress notes maintained. Interview on at approximately 4:15 PM with 2 nurses who were not aware the resident took off the leg brace and stated she was a new admission and they had seen a decline since she had been there. 2. Record review for resident #6 revealed an Assisted Living Facility Health Assessment Form (1823) dated with diagnoses of and type 2 and stated the resident was . The resident was independent with ambulation, eating and transferring and needed supervision with bathing, dressing, and toileting. The resident was identified as receiving an LNS service during the entrance conference. Review of physician order dated stated at 2 liters/minute, apply at bedtime and	AN278		

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AN278	Continued From page 2 remove in AM. There was no documentation to review to indicate nursing progress notes were maintained each time the was administered and removed. Interview with the nurse on at approximately 4 PM who stated the nursing progress notes were maintained each time the LNS service was provided Class III	AN278		

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

2012

Administrator
Emeritus At Conway
5501 East Michigan Street
Orlando, FL 32822

Dear Administrator:

Re: Biennial w/LNS and LNS monitoring

This letter reports the findings of a state licensure 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 **2012,** 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 Lorraine Henry at

Sincerely,

Theresa DeCanio, RN
Field Office Manager

LH/be
Enclosure
XG90

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