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
	AL11953349	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT MYERS	1896 PARK MEADOW DRIVE FORT MYERS, FL 33907

(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 for complaint survey, CCR #2012012151, conducted on [redacted] at Emeritus of Fort Myers, an Assisted Living Facility. This complaint contained three allegations, two which were substantiated with deficiencies cited.	A 000		
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 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 [redacted] Hotline " 1(800)96 or	A 030		

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A 030	Continued From page 1	A 030		

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 [illegible] 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 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 [illegible] 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

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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 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

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facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a [redacted] 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 [redacted], 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 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 [redacted] 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

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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 facility, family, and hospice interviews, resident records reviewed, hospital records reviewed, and observation, the facility failed to protect 1 (Resident #1) of 3 residents reviewed from harm by allowing her to use a heating [redacted]. They neglected to protect her in a safe living environment.

The findings include:

An interview was conducted with Staff A on [redacted] at 10:00 a.m. She stated she found Resident #1 in bed on [redacted] lying on a heating [redacted]. Resident #1 exhibited [redacted]. When they got Resident #1 out of bed they saw her skin where the heating [redacted] was on. The skin was [redacted]. She said the skin looked "red with white splotchy areas and the skin was crinkly" like the top layer of the skin was [redacted] from the lower skin. She called Resident #1's daughter about the heating [redacted]. The daughter said she supplied Resident #1 with the heating [redacted]. She told the daughter a heating [redacted] is not allowed in the facility. She also called Hospice and notified them of Resident #1's injuries. Resident #1 was sent to the hospital. A review of Resident #1's hospital report showed she sustained [redacted] from a heating [redacted] that was left on the patient's [redacted] overnight." "The patient has significant dementia [redacted] cannot provide much of a history." The exam of Resident #1's skin done by the emergency room [redacted]

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"There is an extensive second-degree ... present on the patient's right ... region. It covers almost the entire right ... surface. There is some surrounding first-degree component as well. It is approximately 3-4% body surface area."

At 11:00 a.m. on ... an interview was conducted with Resident #1's daughter. She said she gave her mother the heating ... when she was first admitted to the facility in 2009. The daughter and her brother both asked if Resident #1 can use a heating ... She said Staff C told them a heating ... was ok for Resident #1 to have. Resident #1 always had the heating ... since her admission because she is always ... She said the staff knew the heating ... was in Resident #1's ... they would make her bed with the heating ... was on her bed. Her mother was able to turn the ... on and off. When she would visit her mother the heating ... was moved from time to time. She does not know who moved it. Her mother cannot make her own bed or change her sheets. The past two weeks her furniture was moved twice. When they moved the bed they moved the heating ... also. She is not capable of moving her furniture or plugging and unplugging the heating ... from the wall. She cannot put the heating ... in the closet or drawer to hide it. When she visited her mother the heating ... was always plugged in a surge protector which was plugged in the electrical outlet on the wall next to her bed. Her mother was in Hospice House and was moved back to the facility. Her normal bed was changed to a hospital bed when she returned to the facility on ... The hospital bed was delivered to the facility on ... Someone took the heating ... off the regular bed and left it in Resident #1's ... the dresser. The facility staff helped the

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daughter put the bedding and the heating [illegible] on the hospital bed. She could not remember who the staff was. She also remembered at some point in time the facility changed the carpet to wood floor in Resident #1's [illegible]. They took everything out of the [illegible], including the bed (normal bed), and then the bed was put back in [illegible] the floor was completed. She thinks at some point in time the facility staff had to unplug the heating [illegible] when they moved the bed out of the [illegible] plug it back in the wall when they moved the bed back in the [illegible] the wood floor was completed.

Observation at 2:00 p.m. on 11 [illegible] showed an electrical outlet next to a bed in [illegible] where the resident lived. During this observation the administrator stated Resident #1's bed was located by the window. An electrical outlet was on the wall close to the window.

An interview was conducted with Resident #1's son at 11:20 a.m. on [illegible]. He stated at the time of admission he asked specifically about mom using a heating [illegible]. The female staff told both him and his sister to get a heating [illegible] with an automatic shut off. He could not remember who told him but it was either Staff C, Staff D or the Business Office Manager at that time. The heating [illegible] that was bought was a 10 hour shut off. The heating [illegible] was there the whole time Resident #1 lived at the facility. He visited Resident #1 periodically and this past summer he visited and saw the heating [illegible] box and thinks he saw the heating [illegible] both in Resident #1's [illegible]. He said she can't make up her bed. He thinks she can plug and unplug her heating [illegible] but does not think she can take the heating [illegible] and put it away in the closet or dresser. She could turn [illegible] on and off. He stated the facility

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moved her from [redacted] least once [redacted] and moved to [redacted]. She had a normal bed and brought in the hospital bed in the middle of this year. She lived in hospice for one week and then moved back to the facility. He feels with the move from [redacted] to 29 someone would have to know about the heating [redacted] and moved it with her to [redacted] and when they changed the normal bed to the hospital bed someone would have to take the heating [redacted] off the normal bed and put it on the hospital bed. He stated he was not involved in both of these changes.

Another interview was conducted with Resident #1's daughter. She stated she remembers when her mom moved to [redacted] but could not remember the [redacted] where she used to live. She did not move her mother and did not know who did but her heating [redacted] was moved during this move. She also stated she remembers when her mom's normal bed was changed to a hospital bed. She stated her brother was not involved in both of these moves.

Interviews with both the son and daughter both stated they did not sign the facility contract or knew of the resident handbook informing them there are no heating pads allowed.

An interview was conducted with the maintenance staff on [redacted] at 1:00 p.m. He stated he was not involved when Resident #1's [redacted] changed, the floor was changed from carpet to wood and when the hospital bed was moved in.

An interview was conducted with the Administrator at 1:25 p.m. on [redacted]. She stated the end of 2009 she was the Resident Care Director until [redacted]. She never seen a heating

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She does not remember Resident #1 moving to another . . . I does not remember when the flooring changed. She left the facility and then on 2012 she came back to the facility as the Executive Director. After the incident with Resident #1 on she did the investigation. It showed Staff D knew about the heating . She started in-servicing staff that heating pads are not allowed in this facility.

A review of Resident #1's contract showed Resident #1 signed this contract on . A review of resident handbook shows on page 13 no heating pads allowed in the facility. The facility contract shows by signing this contract she received the resident handbook.

A review of Resident #1's health assessment dated shows Resident #1 requires assistance with toileting, dressing and bathing. She needs supervision with ambulating and is independent with eating and transfers. She has a diagnosis of .

At 12:05 p.m. on an interview was conducted with Staff D. She works with Resident #1 on first and second shift. She said Resident#1 gets out of bed independently. She goes to bed by herself. She cared for Resident #1 on on the 2:00 p.m. -10:00 p.m. shift. She helped hospice nurse and another resident aid put Resident #1 in bed. The heating I was place at the foot of bed. She did not put the heating I on. Another med tech helped with this and the hospice nurse, name unknown, also saw the heating . This was the first time Staff D saw the heating pad. did not know the heating pad not allowed.

At 12:21 p.m. on . . . I interview was

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A 030	Continued From page 9 conducted with Staff E, Hospice nurse by phone. She said she saw the heating on one occasion and reported it to Staff A. Staff A told her Resident #1 has had the heating for a long time so Staff E said she "dropped the issue." An interview was conducted with Resident Care Director at 12:55 p.m. on She said she was not aware Resident #1 had a heating She said she talked with the Hospice supervisor after Resident #1's incident on She said th Hospice supervisor told her some hospice staff saw the heating An interview was conducted with the Hospice Team Manager at 2:00 p.m. on After the incident with Resident #1 on 11 she questioned the nurses and social worker about this heating The nurses and social worker said on various occasions they saw the heating and reported it to facility staff. On the hospice nurse assessed resident with a facility and noted the heating The Hospice staff told her the facility staff told them Resident #1 uses the heating daily for her feet. Class: II Correction Date:	A 030		
A 052	58A-5.0185(3) FAC Medication - Assistance with Self-Admin (3) ASSISTANCE WITH SELF-ADMINISTRATION. (a) For facilities which provide assistance with self-administered medication, either: a nurse; or an unlicensed staff member, who is at least , trained to assist with self-administered medication in accordance with Rule 58A-5.0191, F.A.C., and able to demonstrate to the	A 052		

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administrator the ability to accurately read and interpret a prescription label, must be available to assist residents with self-administered medications in accordance with procedures described in Section 429.256, F.S.
(b) Assistance with self-administration of medication includes verbally prompting a resident to take medications as prescribed, retrieving and opening a properly labeled medication container, and providing assistance as specified in Section 429.256(3), F.S. In order to facilitate assistance with self-administration, staff may prepare and make available such items as water, juice, cups, and spoons. Staff may also return unused doses to the medication container. Medication, which appears to have been contaminated, shall not be returned to the container.
(c) Staff shall observe the resident take the medication. Any concerns about the resident ' s reaction to the medication shall be reported to the resident ' s health care provider and documented in the resident ' s record.
(d) When a resident who receives assistance with medication is away from the facility and from facility staff, the following options are available to enable the resident to take medication as prescribed:
1. The health care provider may prescribe a medication schedule which coincides with the resident ' s presence in the facility;
2. The medication container may be given to the resident or a friend or family member upon leaving the facility, with this fact noted in the resident ' s medication record;
3. The medication may be transferred to a pill organizer pursuant to the requirements of subsection (2), and given to the resident, a friend, or family member upon leaving the facility, with this fact noted in the resident ' s medication record; or

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4. Medications may be separately prescribed and dispensed in an easier to use form, such as unit dose packaging;
(e) Pursuant to Section 429.256(4)(h), F.S., the term " competent resident " means that the resident is cognizant of when a medication is required and understands the purpose for taking the medication.
(f) Pursuant to Section 429.256(4)(i), F.S., the terms " judgment " and " discretion " mean interpreting vital signs and evaluating or assessing a resident ' s condition.
(4) Assistance with self-administration does not include:
(a) Mixing, converting, or medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.
(b) The preparation of syringes for injection or the administration of medications by any injectable route.
(c) Administration of medications through intermittent positive pressure breathing machines or a
(d) Administration of medications by way of a tube inserted in a cavity of the body.
(e) Administration of preparations.
(f) Irrigations or debriding agents used in the treatment of a skin condition.
(g) , or preparations.
(h) Medications ordered by the physician or health care professional with prescriptive authority to be given " as needed, " unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and at the request of a competent resident.
(i) Medications for which the time of administration, the amount, the strength of

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dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

This Statute or Rule is not met as evidenced by:
Based on staff interviews and resident records reviewed, the facility failed to ensure a medication was available for one (Resident #1) of 3 residents when she exhibited The facility did not call the physician when they were no able to follow her order.

The findings include:

An interview was conducted with Staff A, who is an LPN on at 10:00 a.m. She stated she observed Resident #1 exhibit when she found the resident lying in bed on a heating She could not give Resident #1 an because the medication was discontinued on and the new prescription was not filled by the next morning. She called Hospice because Resident #1 was in pain and and had no medication to give her. A review of Resident #1's record showed on the Medication Observation Record and physician order form showed an order for 1 milligram gel. Apply 1 milligram every four hours as needed for This order was written on Further review showed this order was discontinued on and a new order written for .5 milligrams every 8 hour when needed for and .25 milligrams every night.

An interview was conducted with the Resident Care Director on at 11:55 a.m. She said according to the nursing note the order was written at 3:45 p.m. on The cut off for new orders to the pharmacy is 3:00 p.m. The order was faxed to the pharmacy on 2nd shift by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11953349	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT FORT MYERS	1896 PARK MEADOW DRIVE FORT MYERS, FL 33907

(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 052	Continued From page 13	A 052		

the 2nd shift nurse. The last delivery of the day from the pharmacy is approximately 9:00 p.m. Resident #1 would not have gotten the medication that evening .

An interview was conducted with Staff B on at 2:08 p.m. He read the physician's new order for the for Resident #1. He stated the Hospice nurse put this order on the desk and did not tell him about it. He saw the order approximately 3:45 p.m. and faxed it to the pharmacy. He stated if Resident #1 exhibited on second shift he would not be able to give her the since the physician discontinued it. Even though they had this medication available. He was asked why he wouldn't call the physician to not discontinue the gel until the was available the following evening. He stated he follows the physician order and does not question them.

An interview was conducted with the facility administrator at 3:00 p.m. on . She stated the pharmacy has one delivery per day at 8:00 p.m. The facility would have to notify the pharmacy by 3:00 p.m. in order to get these medications by 8:00 p.m. that same day. If the medication is ordered after 3:00 p.m. the medication will not be delivered to the facility until 8:00 p.m. the following day. However, when the physician discontinued .5 milligrams and ordered it orally after 3:00 p.m. on . Resident #1 would not be able to receive this medication until approximately 8:00 p.m. on . Therefore, when Resident #1 exhibited on the morning of the facility did not have the medication to give her as ordered and the facility did not notify the physician this medication was not available.

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A 052	Continued From page 14 Class: III Correction Date:	A 052		
A 077	58A-5.019(1) FAC Staffing Standards - Administrators Staffing Standards. (1) ADMINISTRATORS. Every facility shall be under the supervision of an administrator who is responsible for the operation and maintenance of the facility including the management of all staff and the provision of adequate care to all residents as required by Part I of Chapter 429, F.S., and this rule chapter. (a) The administrators shall: 1. Be at least 2. If employed on or after , 1990, have a high school diploma or general equivalency diploma (G.E.D.), or have been an operator or administrator of a licensed assisted living facility in the State of Florida for at least one of the past 3 years in which the facility has met minimum standards. Administrators employed on or after , 1995, must have a high school diploma or G.E.D.; 3. Be in compliance with Level 2 background screening standards pursuant to Section 429.174, F.S.; and 4. Complete the core training requirement pursuant to Rule 58A-5.0191, F.A.C. (b) Administrators may supervise a maximum of either three assisted living facilities or a combination of housing and health care facilities or agencies on a single campus. However, administrators who supervise more than one facility shall appoint in writing a separate " manager " for each facility who must: 1. Be at least ; and 2. Complete the core training requirement	A 077		

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A 077	Continued From page 15	A 077		

pursuant to Rule 58A-5.0191, F.A.C.
(c) Pursuant to Section 429.176, F.S., facility owners shall notify both the Agency Field Office and Agency Central Office within ten (10) days of a change in a facility administrator on the Notification of Change of Administrator, AHCA Form 3180-1006, 2006, which is incorporated by reference and may be obtained from the Agency Central Office. The Agency Central Office shall conduct a background screening on the new administrator in accordance with Section 429.174, F.S., and Rule 58A-5.014, F.A.C.

This Statute or Rule is not met as evidenced by:
Based on facility staff interviews, family interviews, resident records reviewed, and hospital records reviewed, the administrator failed to provide the appropriate care to one (Resident #1) of 3 resident records reviewed by maintaining a safe environment resulting in on her skin.

The findings include:

An interview was conducted with Staff A on at 10:00 a.m. She stated she found Resident #1 in bed on lying on a heating Resident #1 exhibited When they got Resident #1 out of bed they saw her skin where the heating was on. The skin was She said the skin looked, "red with white splotchy areas and the skin was crinkly" like the top layer of the skin was from the lower skin. Resident #1 was sent to the hospital.

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A 077	Continued From page 16	A 077		

A review of Resident #1's hospital records dated [illegible] showed she sustained [illegible] from a heating [illegible] that was left on the patient's [illegible] overnight." "The patient has significant [illegible] and cannot provide much of a history." The exam of Resident #1's skin done by the emergency [illegible] showed "There is an extensive second-degree [illegible] present on the patient's right [illegible] region. It covers almost the entire right [illegible] surface. There is some surrounding first-degree component as well. It is approximately 3-4% body surface area."

Interviews were conducted with two family members of Resident #1 on [illegible] They both stated Resident #1 used the heating [illegible] every night. When they would visit Resident #1 they would see the heating [illegible] plugged in the electrical outlet on the wall next to her bed. She was not able to make her bed or change her sheets. They feel staff had to have seen this heating [illegible] Her [illegible] changed at one time, the floor was changed from carpet to wood and all of her furniture was moved out of the [illegible] this year her normal bed was changed to a hospital bed. All of these incidents the facility staff performed these functions. The heating [illegible] was in the resident's [illegible] on her bed.

At 12:05 p.m. on [illegible] an interview was conducted with Staff D. She works with Resident #1 on first and second shift. She said Resident#1 gets out of bed independently. She goes to bed by herself. She cared for Resident #1 on [illegible] on the 2:00 p.m. -10:00 p.m. shift. She helped Hospice nurse and another resident aid put Resident #1 in bed. The heating [illegible] was place at the foot of bed. She did not put the heating [illegible] on. Another med tech helped with this and the Hospice nurse, name unknown, also

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saw the heating . This was the first time Staff D saw the heating . She did not know the heating was not allowed.

At 12:21 p.m. on an interview was conducted with Staff E, Hospice nurse, by phone. She said she saw the heating on one occasion and reported it to Staff A. Staff A told her Resident #1 has had the heating for a long time so Staff E said she "dropped the issue."

An interview was conducted with the Administrator at 1:25 p.m. on . She stated the end of 2009 she was the Resident Care Director until . She never saw a heating . She does not remember Resident #1 moving to another does not remember when the flooring changed. She left the facility and then on she came back to the facility as the Executive Director. After the incident with Resident #1 on she did the investigation. It showed Staff D knew about the heating . She started in-servicing staff that heating pads are not allowed in this facility.

These interviews show the facility staff were aware of the heating Resident #1 was using. See A0030 for more details in these interviews. This caused neglect to the resident and A0030 was cited at a class II deficiency. Since this is a class II the administration staff is issued this citation.

Class: II
Correction Date:

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

, 2012

Administrator
Emeritus at Fort Myers
1896 Park Meadow Drive
Fort Myers, Florida 33907

Dear Administrator:

Re: CCR #2012012151

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 afte , 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 this office at 239-335-1315.

Sincerely,

Harold D. Williams
Field Office Manager

HW:ss
Enclosure: State (3020) Form
XG90

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
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