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
	AL11943120	A. BUILDING _____ B. WING _____	R 12/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROTON MANOR	2512 CROTON AVENUE SARASOTA, FL 34239

(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 This is a follow-up to a Biennial survey conducted on 12/12/12 for an Assisted Living Facility, Croton Manor. The Biennial survey was completed 10/04/12. All deficiencies were corrected during this survey revisit.	{A 000}		

AHCA Form 3020-0001

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11943120	A. Building B. Wing	12/12/2012

Name of Facility	Street Address, City, State, Zip Code
CROTON MANOR	2512 CROTON AVENUE SARASOTA, FL 34239

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix A0030 Reg. # 58A-5.0182(6) FAC; 429.28 LSC	Correction Completed 12/12/2012	ID Prefix A0052 Reg. # 58A-5.0185(3) FAC LSC	Correction Completed 12/12/2012	ID Prefix A0057 Reg. # 58A-5.0185(8) FAC LSC	Correction Completed 12/12/2012
ID Prefix A0162 Reg. # 58A-5.024(3) FAC LSC	Correction Completed 12/12/2012	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	AHCA	12-17-12	Eleanor Sevilla, RNS	12-17-12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/4/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

December 17, 2012

Administrator
Croton Manor
2512 Croton Avenue
Sarasota, Florida 34239

Dear Administrator:

This letter reports the findings of a Biennial survey revisit conducted on December 12, 2012 by representative(s) of this office.

Attached is the provider's copy of the Revisit Report, which indicates the previously cited deficiencies were found corrected on the day of the revisit. **You will not receive a copy of this report in the mail; you will only receive this faxed report.**

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
Enclosures: State Form and Revisit Report

Headquarters
2727 Mahan Drive
Tallahassee, FL 32308
http://ahca.myflorida.com

Fort Myers Field Office
2295 Victoria Avenue, Room 340
Fort Myers, FL 33901
Phone (239) 335-1315; Fax (239) 338-2372

REFERRAL TRACKING FORM

Must be completed for every ASPEN Event ID and submitted to field office

Facility	City	Facility Type	Facility Administrator & Fax Number
Croton Manor	Sarasota	ALF	Lost the card phone # same as fax

Event ID#	Survey Date(s)	Survey Type/CCR#(s)
Z1N412	12/12/12	F.U. Biennial

Surveyor(s) Making Referral(s)

N/A

Referral(s) (see below)	Date	Person and Issue
N/A		

1. DOH-MQA
2. DOH-Other
3. Abuse Hotline
4. DFS Fraud Unit
5. County Code Enforcement
6. Attorney General
7. Law Enforcement
8. Fire Marshall
9. Medicaid Fraud Control
10. LTCOC
11. Joint Commission
12. Medicare
13. Medicaid Program Integrity*
14. APD
15. Local Zoning
16. State Attorney
17. CARES Unit

**Choose this before Medicaid Fraud Control*

Comments *(If referral, note who, what, when, where, how, why)*

Instructions

1. Type in the fields, the text will wrap around.

2. This form is required for every Event ID, and if survey covers multiple complaints, you must identify referral status for each.

3. If no referrals are made, indicate as N/A.

4. The pink forms used previously for referrals to DOH-MQA are no longer available; the referral matrix has a link. If link is used from the referral matrix, please print a screen shot of the referral (if able) to include with the survey paperwork.

5. Comments should be as detailed as possible; if call made, give number, date, time, who you spoke to, etc. Provide confirmation number if one is obtained.

TRANSMISSION REPORT

(MON) DEC 17 2012 18:15

User /Account :
DESTINATION : 819419270139
DEST. NUMBER : 819419270139

F-CODE :

PAGES : 4page
RESULT : OK

DOCUMENT# : 7538551-130
TIME STORED : DEC 17 18:13
TX START : DEC 17 18:13
DURATION : 1min. 28sec
COM. MODE : ECM

AGENCY FOR HEALTH CARE ADMINISTRATION
HQA/FT. MYERS

PHONE: (239) 335-1315
FAX: (239) 338-2372

# of Pages (Include Cover Page) 4

DATE: 12/17/12 TIME: 4:40 P.M.

TO: Croton Manor- Administrator - Fax # (941)

FROM: 927-0139

AGENCY FOR HEALTH CARE ADMINISTRATION
HQA/FT. MYERS

PHONE: (239) 335-1315
FAX: (239) 338-2372

# of Pages (Include Cover Page) 4

DATE: 12/17/12 TIME: 4:40 P.M.

TO: Croton Manor - Administrator - Fax # (941)

FROM: 927-0139

[ ] HAROLD WILLIAMS	[ ] BRIANNA WORLEY	[ ] DAVID DAY
[ ] LAURA WERTS	[ ] CHARLENE FISHER	[ ] LYNNE JAMES
[ ] STEVIEE HECKSCHER	[X] ESTELLE CORRALES For Sharon Smith	[ ] ANITA BELLOT
[ ] SHARON SMITH	[ ] HELEN FAISON	[ ] OTHER

RE: Croton Manor - Biennial Survey revisit on 12/12/12

FU 2IN412 12/12
Linked E

FILE REVIEW CORRESPONDENCE SHEET
AREA OFFICE 8

FACILITY NAME: Crotan Manor ALF Biennial

DATE	COMMENTS/ACTIVITY	SIGNATURE
10-10-12	To Harold for signature, then Letter & St of Def. to facility File to waiting FU	D.C.
10-10-12	Letter Dept →	Dpy
10/11/12	Faxed Letter & State form to facility.	E.C.
12/7/12	To Harold for signature, then Letter/St. of Def. to Facility Process File completed	D.C.
12-7-12	Letter Sent → Done	Dpy
12/7/12	Faxed letter & State form to facility.	E.C.