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
	AL11964663	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF FT MYERS	14521 LAKEWOOD BOULEVARD FORT MYERS, FL 33919

(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 to report the findings of a revisit to a Limited Nursing Services survey conducted on [redacted] at Sterling House of Fort Myers, an Assisted Living Facility. The following deficiencies were found to be corrected: A0081, A0083 and 0090. The outstanding deficiency at A0078 was not corrected and was recited.	{A 000}		
{A 078}	58A-5.019(2) FAC Staffing Standards - Staff (2) STAFF. (a) Newly hired staff shall have 30 days to submit a statement from a health care provider, based on a examination conducted within the last six months, that the person does not have any signs or symptoms of a communicable [redacted] including [redacted] Freedom from [redacted] must be documented on an annual basis. A person with a positive [redacted] test must submit a health care provider ' s statement that the person does not constitute a risk of communicating [redacted] Newly hired staff does not include an employee transferring from one facility to another that is under the same management or ownership, without a break in service. If any staff member is later found to have, or is suspected of having, a communicable [redacted] he/she shall be removed from duties until the administrator determines that such condition no longer exists. (b) All staff shall be assigned duties consistent with his/her level of education, training, preparation, and experience. Staff providing services requiring licensing or certification must be appropriately licensed or certified. All staff shall exercise their responsibilities, consistent with their qualifications, to observe residents, to	{A 078}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964663	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF FT MYERS	14521 LAKEWOOD BOULEVARD FORT MYERS, FL 33919

(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 078}	Continued From page 1	{A 078}		

document observations on the appropriate resident ' s record, and to report the observations to the resident ' s health care provider in accordance with this rule chapter.
(c) All staff must comply with the training requirements of Rule 58A-5.0191, F.A.C.
(d) Staff provided by a staffing agency or employed by a business entity contracting to provide direct or indirect services to residents must be qualified for the position in accordance with this rule chapter. The contract between the facility and the staffing agency or contractor shall specifically describe the services the staffing agency or contractor will be providing to residents.
(e) For facilities with a licensed capacity of 17 or more residents, the facility shall:
1. Develop a written job description for each staff position and provide a copy of the job description to each staff member; and
2. Maintain time sheets for all staff.

This Statute or Rule is not met as evidenced by:
Based on staff record review and interview the facility failed to insure 1 (Employee D) of 5 staff records reviewed had documentation of a negative [redacted] test in the employee record.

The findings include:

Review of staff records on [redacted] revealed Employee D did not have documentation in her employee record that she had a negative [redacted] test prior to employment.

In an interview with Executive Director on [redacted] at 4:30 p.m., he confirmed there was no documentation in the employee record that Employee D had the results of her [redacted] test in her employee record. He stated he had called the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11964663	A. BUILDING _____ B. WING _____	R

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING HOUSE OF FT MYERS	14521 LAKEWOOD BOULEVARD FORT MYERS, FL 33919

(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 078}	Continued From page 2	{A 078}		

provider to get the results of Employee D's test but the provider stated Employee D never returned to have her results read.

In an interview with Health and Wellness Director and Executive Director on [redacted] at 4:35 p.m., they verified that Employee D would be taken off the schedule and would not return to work until the facility received documentation of a Negative [redacted] test.

Class III
Correction Date: [redacted]

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
AL11964663	A. Building B. Wing	12/6/2012

Name of Facility	Street Address, City, State, Zip Code
STERLING HOUSE OF FT MYERS	14521 LAKEWOOD BOULEVARD FORT MYERS, FL 33919

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix A0081 Reg. # 58A-5.0191(2) FAC LSC		ID Prefix A0083 Reg. # 58A-5.0191(4) FAC LSC		ID Prefix A0090 Reg. # 58A-5.0191(11) FAC LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By [signature] HFES	Date: 12-11-12	Signature of Surveyor: [signature] for; Cynthia Brandt, RWS	Date: 12-11-12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:

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

, 2012

Administrator
Sterling House of Ft Myers
14521 Lakewood Boulevard
Fort Myers, FL 33919

Dear Administrator:

This letter reports the findings of a revisit survey conducted on , 2012by representative(s) of this office. Enclosed is the provider's copy of the State Form 3020, which references the uncorrected deficiency identified during the revisit.

You will not receive a copy of this report in the mail; you will only receive this faxed report. **The deficiency shall be corrected no later than , 2013.**

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) 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