

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL11911225	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/27/2012
NAME OF PROVIDER OR SUPPLIER EMERITUS AT RIVER OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 925 SOUTH RIVER ROAD ENGLEWOOD, FL 34223		
(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 the 2nd follow up conducted on 12/27/12, to an Extended Congregate Care survey, at Emeritus at River Oaks, an Assisted Living Facility. The previously cited deficiency was cleared.	{A 000}			

AHCA Form 3020-0001

TITLE

(X6) DATE

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

STATE FORM

6899

P42F13

If continuation sheet 1 of 1

1/4/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number AL11911225	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 12/27/2012
Name of Facility EMERITUS AT RIVER OAKS		Street Address, City, State, Zip Code 925 SOUTH RIVER ROAD ENGLEWOOD, FL 34223

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 12/27/2012	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
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Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	<i>Quincy HFS</i>	<i>1-4-13</i>	<i>Tawny Alter, HFS</i>	<i>1-4-13</i>
Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
CMS RO				
Followup to Survey Completed on: 8/14/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		



RICK SCOTT
GOVERNOR

Better Health Care for all Floridians

ELIZABETH DUDEK
SECRETARY

January 4, 2013

Administrator
Emeritus at River Oaks
925 South River Road
Englewood, Florida 34223

Dear Administrator:

This letter reports the findings of an Extended Congregate Care survey second revisit conducted on December 27, 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
Enclosure

J5XD

