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 |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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<br><br>These are the results for Complaint survey CCR# 2012012693 conducted on [redacted] at Sterling House, an Assisted Living Facility.<br><br>The complaint contained one allegation which was not substantiated. However, deficiencies were cited. | A 000 | | |
| A 030 | 58A-5.0182(6) FAC; 429.28 FS Resident Care - Rights & Facility Procedures<br><br>(6) RESIDENT RIGHTS AND FACILITY PROCEDURES.<br>(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.<br>(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.<br>(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.<br>(d) The statewide toll-free telephone number of | A 030 | | |

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 |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 030 | Continued From page 1 | A 030 | | |

the Florida ..... Hotline " 1(800)96 or 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 ..... 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 ..... 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

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 |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 030 | Continued From page 2 | A 030 | | |

resident ' s representative. Any device, including 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

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 |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 030 | Continued From page 3 | A 030 | | |

attorney in fact authorizes the administrator of the facility to provide safekeeping for funds as provided in s. 429.27.
(g) Share a . . . 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 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 , interference, coercion, discrimination, or reprisal. Each facility shall establish a grievance procedure to facilitate the residents ' exercise of this right. This right

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 030 | Continued From page 4<br>includes access to ombudsman volunteers and advocates and the right to be a member of, to be active in, and to associate with advocacy or special interest groups.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure residents civil rights were protected by failing to ensure refunds were provided as required by law for 3 (Residents #1, #3, and #5) of 3 residents reviewed who required a refund.<br><br>429.24(3)(a) The contract shall include a refund policy to be implemented at the time of a resident 's transfer, discharge, or ..... The refund policy shall provide that the resident or responsible party is entitled to a prorated refund based on the daily rate for any unused portion of payment beyond the termination date after all charges, including the cost of damages to the residential unit resulting from circumstances other than normal use, have been paid to the licensee. ..... The facility shall provide a refund to the resident or responsible party within 45 days after the transfer, discharge, or ..... of the resident. The agency shall impose a fine upon a facility that fails to comply with the refund provisions of the paragraph, which fine shall be equal to three times the amount due to the resident. One-half of the fine shall be remitted to the resident or his or her estate, and the other half to the Health Care Trust Fund to be used for the purpose specified in s. 429.18.<br><br>The findings include: | A 030 | | |

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 |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 030 | Continued From page 5 | A 030 | | |

1. A review of Resident #1's contract on revealed the agreement was signed on The Executive Director and Sales and Marketing Manager were given verbal notice by Resident #1's family on and the furniture was removed a few days later. The financial responsibility end date was as Resident #1 was not going to come to the facility and the facility rented the someone else on

Review of Resident #1's contract and financial account at 11:25 a.m. on revealed a non-refundable community fee due for $2500.00 however only 2 payment of $834.00 and $833.00 were received before the sister decided not to bring him to the facility. The contracted charges included base rate of $3300.00 and Personal service rate of $1975.00 or $5275.00 monthly. The family member gave the facility a check #2334 on for $6565.69 and began moving in personal items and furniture. The considered occupied from to ; when it was cleared of belongings and rented to another individual. The personal services charges were not charged. A refund check was issued on for $3157.73. The facility retained $3408.39 for the non-refundable community fee of $1667.00 plus the prorate of $1741.39. $3300.00 prorated daily is 108.20 per day. 17 days of should be $1839.40; however the facility only kept $1741.39 and undercharge of $98.01.

At 12:07 p.m. the Executive Director stated she would get the document of refund from corporate. Records show the refund of $3157.73 for Resident #1 was mailed on to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 030 | Continued From page 6 | A 030 | | |

is 51 days not 45; 6 days late.

2. At 12:53 p.m. a review of financial records for Resident #3 revealed was the resident admitted on and signed the residency agreement on . The contract revealed charges including a non-refundable community fee of $2500. 00; basic service rate of $3100. 00; and Personal Service rate of $1095.00, totaling a monthly rate of $4195.00. He on $4195.00 divided by 31 days = $27.29 a day x 10 days from =$ 272.90. The refund mailed on was $377.00 (an overpayment of $104.10) but 14 days late. to is 58 days not 45, 13 days overdue.

3. At 1:19 p.m. review of financial record for Resident #5 who was admitted on and expired on was completed. A review of the contract revealed a non-refundable community fee of $2500.00; a Base rate of $3100. 00; a Personal service rate of $567.00 for a total monthly rate of $3667.00. Resident #5 also had a first personal service rate increase on from $567.00 to $698.00 for the therapeutic diet was mailed on . The second rate increase was on for mobility escort, bowel and , and from $698.00 to $1269.00 for which was also mailed to his healthcare surrogate but facility never received signed copy back. Therefore, $3100.00 plus $1269.00 = $4369.00 monthly.

$1269. divided by 31 days = 40.94 x 19 =777.86 plus $ 3100.00 divided by 31 = $100.00 a day belongings were moved out on : = 15 days x 100 = 1500 + 777.86 = 2277.86 $830.06 short of refund.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 030 | Continued From page 7<br><br>telephone interview with the Collection Analyst, for the facility at 2:53 p.m. regarding Resident #5 revealed the family paid $3798.00 for but did not pay for the increased rate for either month and . The family paid $3798.00 for 2012 but owed $224.64 from 2012. The $3798-224.64 =3573.36. The personal service fee for 2012 dates of is$ 40.94 x 12 days = $491.28. 3298.00 + 491.28 = $3082.08 minus 1600.00 as furniture was not removed until 1482.08 which is a difference of $34. 28 and not paid timely.<br><br>The difference is because as the contract notes - the prorating is at 30.5, not 28, 30 or 31 depending on the month.<br><br>The refund of $1447.80 was mail on , to is 48 days not 45; 3 days late.<br><br>Class III | A 030 | | |
| A 032 | 58A-5.0182(8) FAC Resident Care - Elopement Standards<br><br>(8) ELOPEMENT STANDARDS.<br>(a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement shall be identified so staff can be alerted to their needs for support and supervision.<br>1. As part of its resident elopement response policies and procedures, the facility shall make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility ' s name, address, and telephone number. Staff attention shall be directed towards residents assessed at | A 032 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 032 | Continued From page 8<br>high risk for elopement, with special attention given to those with 's and related assessed at high risk.<br>2. At a minimum, the facility shall have a photo identification of at risk residents on file that is accessible to all facility staff and law enforcement as necessary. The photo identification shall be made available for the file within 10 calendar days of admission. In the event a resident is assessed at risk for elopement subsequent to admission, photo identification shall be made available for the file within 10 calendar days after a determination is made that the resident is at risk for elopement. The photo identification may be taken by the facility or provided by the resident or resident ' s family/caregiver.<br>(b) Facility Resident Elopement Response Policies and Procedures. The facility shall develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures shall include:<br>1. An immediate staff search of the facility and premises;<br>2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities;<br>3. The identification of staff responsible for contacting law enforcement, the resident ' s family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and<br>4. The continued care of all residents within the facility in the event of an elopement.<br>(c) Facility Resident Elopement Drills. The facility shall conduct resident elopement drills pursuant to Sections 429.41(1)(a)3. and 429.41(1)(l), F.S. | A 032 | | |

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 |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 032 | Continued From page 9 | A 032 | | |

This Statute or Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure all direct care staff participated in a minimum of two elopement drills annually for 5 (Staff J, L, M, S, and Y) of 23 staff currently employed as Administration or direct care.

429.41(1)3 F.S. Resident elopement requirements.-Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.

429.41 (1)3(l) F.S. The establishment of specific policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills. Facilities shall document the drills.

The findings include:

1. Record review revealed that Staff J was hired on [redacted] as a CNA. A review of all the elopement drill documentation found Staff J did not participate in any drills in 2012.

2. Record review revealed that Staff L was hired on [redacted] as a CNA. A review of all the elopement drill documentation found Staff L participated in only one drill in 2012, on [redacted].

3. Record review revealed that Staff M was hired

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 032 | Continued From page 10<br><br>on [redacted] as a CNA. A review of all the elopement drill documentation found Staff M participated in only one drill in 2012, on [redacted].<br><br>4. Record review revealed that Staff S was hired on [redacted] as a CNA/Med Tech. A review of all the elopement drill documentation found Staff S participated in only one drill in 2012, on [redacted].<br><br>5. Record review revealed that Staff Y was hired on [redacted] as a LPN. A review of all the elopement drill documentation found Staff Y participated in only one drill in 2012, on [redacted].<br><br>Class III | A 032 | | |
| A 167 | 58A-5.025(1) FAC Resident Contracts<br><br>Resident Contracts.<br>(1) Pursuant to Section 429.24, F.S., prior to or at the time of admission, each resident or legal representative shall execute a contract with the facility which contains the following provisions:<br>(a) A list of the specific services, supplies and accommodations to be provided by the facility to the resident, including limited nursing and extended congregate care services if the facility is licensed to provide such services.<br>(b) The daily, weekly, or monthly rate.<br>(c) A list of any additional services and charges to be provided that are not included in the daily, weekly, or monthly rates, or a reference to a separate fee schedule which shall be attached to the contract.<br>(d) A provision giving at least 30 days written notice prior to any rate increase.<br>(e) Any rights, duties, or [redacted] of residents, other than those specified in Section 429.28, F.S.<br>(f) The purpose of any advance payments or deposit payments and the refund policy for such | A 167 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 167 | Continued From page 11 | A 167 | | |

advance or deposit payments.
(g) A refund policy which shall conform to Section 429.24(3), F.S.
(h) A written bed hold policy and provisions for terminating a bed hold agreement if a facility agrees in writing to reserve a bed for a resident who is admitted to a nursing home, health care facility, or facility. The resident or responsible party shall notify the facility in writing of any change in status that would prevent the resident from returning to the facility. Until such written notice is received, the agreed upon daily, weekly, or monthly rate may be charged by the facility unless the resident ' s medical condition, such as the resident ' s being comatose, prevents the resident from giving written notification and the resident does not have a responsible party to act in the resident ' s behalf.
(i) A provision stating whether the organization is affiliated with any religious organization, and, if so, which organization and its relationship to the facility.
(j) A provision that, upon determination by the administrator or health care provider that the resident needs services beyond those the facility is licensed to provide, the resident or the resident ' s representative, or agency acting on the resident ' s behalf, shall be notified in writing that the resident must make arrangements for transfer to a care setting that has services needed by the resident. In the event the resident has no person to represent him, the facility shall refer the resident to the social service agency for placement. If there is disagreement regarding the appropriateness of placement, provisions as outlined in Section 429.26(8), F.S., shall take effect.
(k) A provision that residents must be assessed upon admission pursuant to subsection 58A-5.0181(2), F.A.C., and every 3 years

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 167 | Continued From page 12<br>thereafter, or after a significant change, pursuant to subsection (4) of that rule.<br>(l) The facility ' s policies and procedures for self-administration, assistance with self-administration and administration of medications, if applicable, pursuant to Rule 58A-5.0185, F.A.C. This also includes provisions regarding over-the-counter (OTC) products pursuant to subsection (8) of that rule.<br>(m) The facility ' s policies and procedures related to a properly executed<br><br>This Statute or Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure all addenda are signed by both parties for 1 (Resident #5) of 4 residents contracts reviewed.<br><br>The findings include:<br><br>1. At 1:19 p.m. a review of the financial record for Resident #5 who was admitted on ... and expired on ... was completed. A review of the contract revealed a non-refundable community fee of $2500.00; a Base rate of $3100. 00; a Personal service rate of $567.00 for a total monthly rate of $3667.00. Resident #5 also had a first personal service rate increase on ... from $567.00 to $698.00 for the therapeutic diet was mailed on , but never signed any returned by the facility. The second rate increase was on ... for mobility escort, bowel and , and from $698.00 to $1269.00 for which was also mailed to his healthcare surrogate but facility never received signed copy back. Therefore, $3100.00 plus $1269.00 = $4369.00 monthly. | A 167 | | |

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 |
|---|---|---|---|
| | AL11964874 | A. BUILDING _____ B. WING _____ | |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| STERLING HOUSE OF CAPE CORAL | 1416 COUNTRY CLUB ROAD CAPE CORAL, FL 33990 |

| (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 167 | Continued From page 13<br><br>2. During an interview on , with the Executive Director of the facility, she stated she calls the families to tell them when a personal service rate is increased due to a change in condition. The rate is then verbally agreed by the family and the paperwork is sent to them to sign and return. She verified she had received neither sign addenda from or for Resident #5.<br><br>3. On , a telephone interview with the Collection Analyst, for Sterling House Corporate at 2:53 p.m. regarding Resident #5 revealed the family paid $3798.00 for but did not pay for the increased rate for either month and . The family paid $3798.00 for 2012 but owed $224.64 from 2012. The $3798-224.64 =3573.36.<br><br>Class III | A 167 | | |

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

RICK SCOTT
GOVERNOR

*Better Health Care for all Floridians*

ELIZABETH DUDEK
SECRETARY

, 2013

Administrator
Sterling House of Cape Coral
1416 Country Club Road
Cape Coral, Florida 33990

Dear Administrator:

Re: CCR #2012012693

This letter reports the findings of a complaint survey that was conducted on , 2013 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 , 2013 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 Form

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

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